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JAN 9 1934

THE JOURNAL FOR DENTISTS

# ORAL HYGIENE

January  
1934

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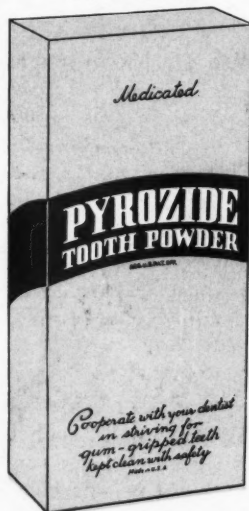
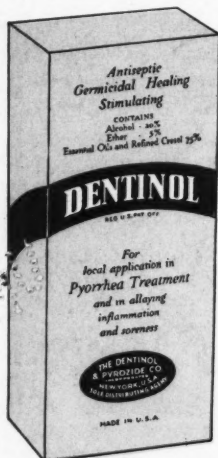
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No. 150

# CORNER

By MASS

BORNE down by its famous inferiority complex, this department and its conductor seldom if ever intrude upon the regular text section of ORAL HYGIENE. The yibbling is confined to this walled-off spot in the magazine, a cul-de-sac remote from the chaste professional atmosphere created by writers who, one wistfully remembers, long ago got over being just plain misters. Writing men who have earned degrees would scarcely relish the companionship even in print of one who is entirely destitute of such alphabetical adornment.

In plain English: old Mass knows his place, tries not to forget it, and stays where he belongs on this little desert island of text surrounded by some pretty advertisements.

But this month I broke the rule and, under the masthead on page 58, penned a stagey and self-conscious message to the customers announcing the appointment of Oral Hygiene Publications' new editorial director, Doctor Edward J. Ryan.

And after I finished it, and Mary Connally put in some more commas, and sewed up some split infinitives, and chromium plated some of my phrases, I felt a yearning to divest myself of the rhetorical frock coat and get back over here where I belong, in my shirt sleeves, back in the CORNER where I wouldn't feel obliged to talk about Doctor Edward J. Ryan but could call him Ed.

For he is Ed Ryan to me—for all his erudition, for all the respect he commands and in spite of his professional

stature. Although he knows a great deal more, infinitely more than I (who turned up missing in educational circles just a little after the sophomore year in high school) I discovered that we were on the same wire the very first time we met. That was at luncheon one day in Chicago, during one of the Chicago Dental Society's midwinter meetings.

Naturally the talk veered to dental journalism, and I found presently that Ed had some crystal-clear and quite definite ideas on the subject—that he could take some smoky thought of mine and, stripping away its cloudiness and uncertainty, return it to me bright and shining.

He was in practice then—as now. Previously, after graduating at Illinois in 1921, and attending the Lewis Institute of Technology, he had for seven years been instructor and associate in operative dentistry and oral surgery at his alma mater—and, at the University of Chicago had served on the clinical staff of the Rush Medical College Dispensary. But, before he earned his dental degree, before he became a bachelor of science, he had been a newspaper reporter for a while, and the dear aroma of printers' ink still haunted him, and perhaps because my own veins run black with the fascinating fluid we understood each other from the start and were old friends within the hour.

So it was the most natural thing in the world to think of Ed when we were starting the new *Dental Digest*. We discussed it in Chicago where I went to see him about it, pretty well settling it while standing on the L steps out at Rogers Park, and decided definitely one Sunday a little later, talking it over as we tramped the Pennsylvania hills, finally shaking hands on it across a rickety garden table in my backyard.

Well, several thousand people know what happened—know the kind of magazine he created, the pace he has maintained.

*The Dental Digest* has not been edited from a swivel chair. The originality and vitality Ed has poured into it have not come to life in an atmosphere of pencils and pads,

scissors and paste—have been born, instead, in daily contact with patients, in frequent association with other dentists in Ed's own dental society activities, and, outside Chicago, in cities and towns to which he is invited as guest speaker.

He has been editing *The Dental Digest* standing up, and walking around—not from an inaccessible editorial cloister. Most of the desk work he delegates to the experienced hand of Ethel Davis, assistant editor. She worries capably about the commas and semicolons and a host of other things more difficult to care for. Bob Ketterer frets about the size of pictures, the niceties of page balance, the overset lines which must be backed up to square a page.

Ed stays in the thick of dental life, observing and absorbing, matching minds with other men—among dentists, among patients. At intervals, in his editorial office at Evanston, in his cabin at Pinecliff on Rock River, he catches up with his manuscript reading, his writing, his editorial correspondence.

Now that he has become editorial director of all three papers—with over 100,000 of them going out each month—he is organizing his new work in the same way, depending upon further capable assistance to leave him free of burdensome detail so that he may continue to edit from the spots where things are happening, where various phases of the dental life are being lived.

A war correspondent must be where the bullets sing. He must be at the war. An editor, if he is to appraise accurately and interpret vividly, must be in the midst of the life he is to appraise and interpret. There is where you will find Ed.

---

# THE ARISTOCRAT of Dental Restorations



**M**OST artificial teeth are simply veneers which add natural appearance to a bridge, such as Steele's Facings. In Steele's Trupontics this veneer is so designed as to replace practically all advantages of natural teeth. Strength, beauty, natural tissue contact and dependability are all features of Trupontics, truly the "Aristocrat of Fixed Bridge Restorations."

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**Trupontics**  
INTERCHANGEABLE  
PAT. PENDING

ONCE USED ...  
ALWAYS  
PREFERRED

THE COLUMBUS DENTAL MFG. CO., Columbus, Ohio, U.S.A.

*If you are in doubt  
about the dentifrice  
you recommend*

## **REMEMBER THIS**

You unquestionably agree with us that serious consequences are likely to follow neglect of the teeth. Your patient and the public are entitled to this information, but they need not live in constant fear.

We urge that they see you for an examination, say every five or six months, and that they supplement your professional care with the regular use of Squibb Dental Cream.

Squibb Dental Cream was produced by our scientific staff after thorough research and correlation of all existing scientific information upon the problem. It cleans effectively and polishes safely with absolute freedom from harsh abrasives. It gives all the help any dentifrice can give to promote the health of the gums—by *safe cleaning*, not by the use of dangerous astringents or any other irritating substances. And its use is true economy.

When your patients use Squibb Dental Cream, tiny particles of Milk of Magnesia are forced into sheltered areas to neutralize bacterial and other acids which result from food decomposition.

Let us send you a sample of Squibb Dental Cream for your personal use. We know you will enjoy its delightful flavor and the clean, refreshed feeling it leaves in your mouth. And you will have no doubt about recommending it to your patients, for you can trust its complete safety and efficacy.

# SQUIBB'S DENTAL CREAM



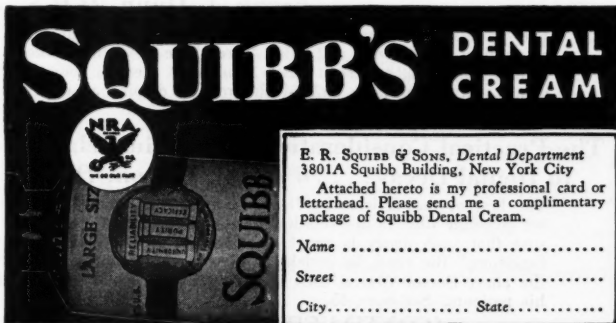
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3801A Squibb Building, New York City

Attached hereto is my professional card or letterhead. Please send me a complimentary package of Squibb Dental Cream.

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Street .....

City..... State.....





## Preventive Dentistry 1934

*Howard R. Raper, D.D.S., F.A.C.D.* 20

"Preventive dentistry as practiced and understood is a failure and a hoax," says Howard Raper. Fighting words! And quite likely the editor will hear from more than one reader who disagrees with the author. (Whisper: the latter's address is printed at the end of his article.) Two plain little pages full of dental dynamite.

## A Yardstick for Dental Fees

*Burke W. Fox, D.D.S.* 22

Doctor Fox tells how his dental society investigated fees—how 48 out of 51 members furnished individual fee schedules which made possible the compilation of an interesting and helpful table, which is, says Doctor Fox, "frankly an experiment. Where do you think our scale is wrong?"

## Writing Without Hands . . . . . *M. E. Hopkins* 27

How a dentist contrived a device which enables a patient "to read and to write, although he is paralyzed and has no use of his hands." An inspiring single page article.

## Results from a School Program . . *Ida Mae Stilley* 28

Miss Stilley tells how she made a school dental hygiene program produce results over a three-year period. Her success has been due to intelligent patience and ingenuity. "My dental engine took wings and became an airplane in which one might fly to see a grandma or an aunt." Perfect attendance records rose from 92 to 204.

## Henrik Shipstead, United States Senator

*Frank A. Dunn, D.D.S.* 36

The profession's biographer goes to the national capital for his subject this month and asks, "Are there not others like Henrik Shipstead? Aren't there, in your dental society, hands that might have swayed the rod of empire as deftly as they do an excavator or a pair of forceps?"

## The Practical Consideration of Diet in Relation to Dental Decay . . . *Waite A. Cotton, D.D.S.* 42

The first of two articles by Doctor Cotton, who says, "When we consider diet in its relation to dental decay, we can be sure that such decay is proof of disturbed or changed body functions." But read the article! And you may have a copy of the chart Doctor Cotton uses in his own practice to instruct his patients. See page 45.

(CONTINUED ON PAGE 19)

(CONTINUED FROM PAGE 16)

“Why Doesn’t Dr. Dean Learn Nerve Block?”

*Jos. B. Jenkins, D.D.S.* 48

“After a moment the assistant turned and gravely announced ‘Doctor, it’s a lawyer, wishing to speak to you, personally.’”  
What about? Well, it’s too long to tell here in the table of contents.

Brother Bill’s Letters

*George Wood Clapp, D.D.S.* 52

The fifth of the new series, and this letter is one of the most interesting so far. “If you don’t know how to find out what is needed, how can you expect the laboratory man to construct the pieces that should be required?”

Editorial ..... 58

A special announcement by the publisher.

Greater New York Meeting Draws 5000 ..... 61

Indicating rather definitely that the profession’s economic status is improving. Many came from distant points to participate in last month’s convention atop Hotel Pennsylvania.

Ask Oral Hygiene . . . *V. Clyde Smedley, D.D.S.*

*and George R. Warner, M.D., D.D.S.* 67

The letters sent this department would overflow each issue of the entire magazine. Here are four pages of them.

Dear Oral Hygiene ..... 71

And we wish there were room to print *all* the interesting editorial mail ORAL HYGIENE receives.

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# Preventive Dentistry

## 1934

By HOWARD R. RAPER, D.D.S., F.A.C.D.

**P**REVENTIVE dentistry as practiced and understood is a failure and a hoax.

What has the aim of preventive dentistry been? I think I answer the question correctly when I say it has been to prevent caries, that is, common decay of teeth.

And what are the means of preventing caries? Measures for preventing dental decay may be classified under three heads: (a) diet, (b) home care or prophylaxis, and (c) prophylaxis or cleaning administered in a dental chair.

Now let us put ourselves in the patient's place. We want to practice preventive dentistry, that is to say we want to do something to keep our teeth from decaying. There are three ways open to us, as I have just pointed out, namely, diet, home scrubbing, and going to the dentist. Of these, by far the most expensive is going to the dentist. Times are hard. Why go to the dentist? Why not try diet and a new toothpaste?

Why not indeed? And so today, preventive dentistry is not being practiced in dental

offices at all. It is being practiced in dining rooms and bath rooms. People eat a little more spinach, get a new toothbrush with a crooked handle, look around for the most magical of the many magical toothpastes, and proceed to rub their teeth regularly and vigorously, hoping thereby to prevent dental decay.

And what are the results? The teeth keep on decaying of course. Not so much decay occurs we feel sure, but cleaning the teeth does not prevent all or anywhere near all decay. Nor does diet, home care, and prophylaxis by the dentist combined prevent all decay for the average individual.

I should make it clear that I assuredly have no objections to people brushing their teeth and eating good food. The teeth should be brushed to keep the mouth from becoming foul and eating is necessary to life. But I do insist, with vehemence, that there is something to preventive dentistry *besides* rubbing the teeth with a paste of calcium carbonate and drinking orange juice and cod liver oil.

The aim of preventing dental decay is mischievous for two reasons. It keeps people away from dentists, and, because it is an unattainable goal for more than ninety per cent of the people, it causes widespread discouragement. I believe all dentists have heard people say something like this, "Oh, there is no use trying to save my teeth. I have done everything, and they just keep right on decaying."

What we need in the field of preventive dentistry, and we need it badly, is a *new aim*, and one that is attainable. That new aim should be the *prevention of toothache*.

Toothache (pulpitis, pericementitis, and periapical osteitis) can be prevented by finding and filling all cavities, before they involve the pulp. This can be done *ONLY* by dentists. It is a goal obtainable by the great majority of people. It is not another false alarm.

Isn't it ironic that the manufacturers of tooth toilet articles, with dentists' help, should have sold the people the hope of preventing caries although they cannot "deliver the goods," while dentists have not sold the hope of preventing toothache, which, given a chance, they *can* deliver to the great majority of people?

Promising prevention of toothache is risky in the absence of x-ray examination. At

the very time the promise is made a hidden proximal cavity may be just about to shatter it by attacking the pulp. The interproximal x-ray examination, which can be made in only five exposures, insures the discovery of practically all proximal cavities before they become large enough to endanger the pulp. Because of the few x-ray exposures required, interproximal, or bite-wing, examination is less expensive, and is consequently practical as a means of periodic examination.

As I have written elsewhere, "prevention of caries is something to strive for or dream about, prevention of toothache is something to *do*." Need I add that the prevention of toothache means the prevention of pulpless teeth, the kind of teeth which cause focal infection which in turn causes innumerable systemic diseases? Thus the prevention of toothache is something more than just the prevention of a dental pain; it is a health service—of the first rank.

Prevention of the development of pyorrhea to an incurable stage is another kind of preventive dentistry that can be accomplished, where it can be accomplished at all, by dentists only. Like the prevention of toothache, it is so eclipsed by the prevention-of-caries idea that the people know little or nothing about it.

1516 East Silver Avenue  
Albuquerque, New Mexico

# A YARDSTICK *for* Dental Fees

By BURKE W. FOX, D.D.S.

**A**FTER thirty years practice," remarked a veteran dentist, "It is my opinion that dental fees are charged on no logical basis, but on what the traffic will bear,—or rather what the dentist *thinks* the traffic will bear."

The correct scale for dental fees will never be determined until fees are brought out into the light and properly analyzed. Under the New Deal it is considered unethical for a merchant to sell goods as a "leader" at less than cost, and some of the codes require that a certain fixed margin of profit be made on every article. Even the code proposed for the dental laboratories had a specification in it which would prevent the laboratory from charging a fee for his work which would not give a margin of fifteen per cent profit.

The condition of dentistry itself, however, is almost as chaotic as it has ever been in spite of the interest in economics during the past few years. Fees based on time required are logical, yet the old idea of being able to get

a better fee for gold, or a bridge or denture which was something the patient could see, was so deeply rooted that dentists still seem to be doing at a loss treatments and operations which require little in the way of materials.

Before the day of the "hot seat" it was bad taste to mention rope in the presence of the family of a man who had been hanged. Dentists seemed to feel it as equally bad taste to talk concretely about fees, or at least to give honest figures. At a small-town dental meeting the dentists wrote down their fees on paper and turned them in anonymously. When the results were read, the youngest dentist present rose.

"Gentlemen," he said, "three years ago when I came to this town I decided to try to run my practice on a sound basis. So I went to each of you and asked about your fees to determine what mine should be. If you have given true figures here, then you must have told me the fees you would like to charge if you could. The funny thing

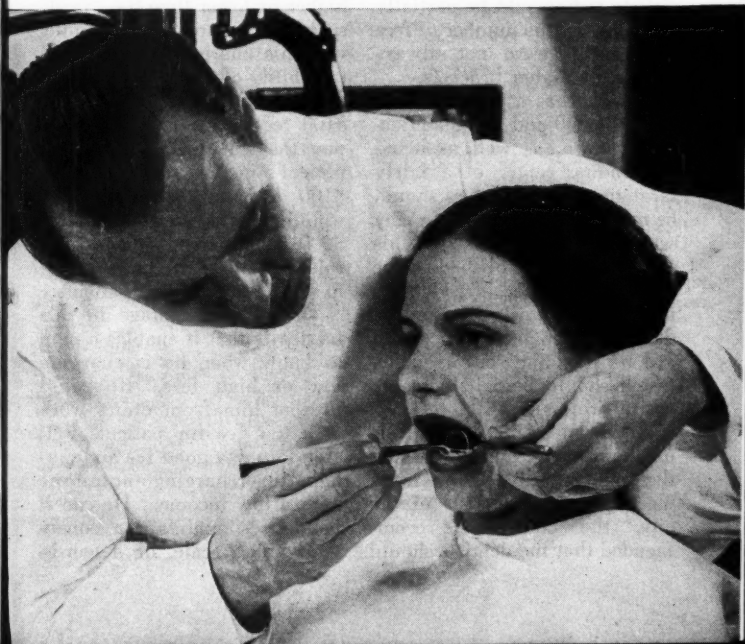
though, is that I have actually been *getting* those fees." This seems to prove the statement made in the beginning, that dental fees are based on what the dentist thinks "the traffic will bear."

A short time ago, our local dental society decided to investigate this matter of fees and appointed a committee to check and make recommendations. A questionnaire with about fifty items was made up and sent to all the dentists of the city with the request that *minimum* fees be given and returned anonymously, the committee thus hoping to get a true return. Forty-eight of fifty-one sent out were returned and the analysis of these figures was most in-

teresting. It proved that our fee system is very inconsistent.

On certain items, such as amalgam fillings, x-ray pictures, and extractions, the fees were fairly equal, but on other items the fees ran over wide ranges. Porcelain jackets ran from fifteen to fifty dollars—root canal fillings from two dollars to thirty. And the peculiar thing was that a man might be among the higher brackets in most of his items, yet among the cheapest in a few. Not a man was absolutely in line all the way down the list.

Some of the fees when examined carefully seemed to lack reason. For instance, one man reported twenty dollars



for a single denture, and eighty for an upper and lower. Another, twenty-five and one hundred; another fifteen and fifty. Many of the men reported a higher fee for a palatal bar than for a lingual bar.

The most illogical fees were on the bridgework. Thirteen men reported a fee for each bridgework unit which would make a three-tooth bridge cost about the same as two two-surface inlays, or less than two three-surface inlays. And yet who is going to put in a bridge without having two- or three-surface inlays for abutments? A typical example is this: two-surface inlay, \$20; three-surface inlay, \$25; bridgework per tooth, \$15. Another interesting fact noted was that the specialists (who could be partially identified by the number of fees they gave) were not always among the higher brackets.

Our city has a population of about 85,000 and is a manufacturing town, as well as being the trading center of a fairly large territory. The fees should be more or less typical of many sections of the country, but this study is being published in the hope that further investigation in other sections will produce data from which a better standard of fees may be arranged, which should be a help to the entire profession.

After canvassing the analysis of the returns and discussing the matter extensively in a meeting of the dentists of the city, the committee recommended that the dentists should

adopt basic or "yardstick" fees for their guidance. These fees recommended would be in no way obligatory, but merely for information.

The fees recommended by the committee, while not based on thoroughly accurate time studies, were adjusted on what we felt was about eight dollars an hour. Figuring on one thousand productive hours a year, with an overhead of about \$3000, a man should make about \$4500 if he is a good collector. If he has an overhead of \$1800 and wishes to make about \$2500, then he could make his fees about one third less than the "yardstick" scale.

A further variation was recommended. After determining whether his scale should be higher or lower than the "yardstick" scale, each dentist should vary his charges according to the ability of the patient to pay. The patient with an income of \$100 to \$200 a month, would pay the standard fee. If the patient's income were less than \$100 a month, then the fee would be lowered—if above \$200 a month, it should be raised to offset the lack of profit on the low income patients.

The only advantage in this fee list is that it enables a man to know when he is charging low or high fees. It should prevent him from doing work at a low fee for patients well able to pay a good fee and perhaps overcharging someone with a low income. He can if he desires, maintain a consistently high scale, or a consis-

	Lowest	Highest	Most Popular		Average	Basic Fee
Amalgam						
1-surface	1.00	3.00	2.00 (26)		2.12	2.50
2-surface	2.00	4.00	2.00 (14) 3.00 (15)		2.84	3.50
3-surface	2.00	6.00	3.00 (19) 5.00 (12)		3.59	5.00
Temporary teeth (Amalgam or cement)	1.00	3.00	1.00 (10) 2.00 (17)		1.78	2.00
Gold inlays						
1-surface	5.00	15.00	10.00 (18)		9.71	12.50
2-surface	5.00	22.50	10.00 (9) 12.00 (11)		12.90	16.00
3-surface	8.00	30.00	15.00 (13)		16.20	20.00
Bridgework per tooth						
Fixed	8.00	15.00	10.00 (17) 15.00 (17)		12.93	15.00
Removable (Gold—per unit)	8.00	30.00	15.00 (13)		16.25	20.00
Vulcanite	4.00	15.00	10.00 (4) 15.00 (6)		10.95	5.00
Gold crowns	8.00	15.00	10.00 (20) 15.00 (13)		11.90	15.00
Porcelain Inlays	7.00	30.00	15.00 (6) 25.00 (5)		16.67	20.00
Porcelain Jacket	15.00	50.00	35.00 (15)		34.21	50.00
Silicate	1.50	5.00	3.00 (16)		3.08	4.00
Extract single tooth (with anesthetic)	1.00	4.00	2.00 (30)		2.20	3.00
Each additional	.50	5.00	1.00 (10) 2.00 (16)			2.00
Temporary teeth	.50	3.00	1.00 (18) 2.00 (16)		1.46	2.00
X-rays						
Single	1.00	5.00	2.00 (21)		2.30	2.50
Each additional	1.00	2.50	1.00 (15) 2.00 (20)		1.33	1.00
Full-mouth	10.00	20.00	10.00 (21) 15.00 (17)		12.40	15.00
Gum treatments	1.00	3.00	3.00 (13)		2.54	2.50
Trench mouth—(Visit)	1.00	3.00	2.00 (13) 3.00 (10)		2.56	5.00
Pyorrhea						
Conserv.	2.00	25.00	3.00 (13)		3.24	\$8 per hour
Surg. per tooth	1.00	15.00	5.00 (5)		4.85	5.00
Prophylaxis	1.00	5.00	2.00 (16) 3.00 (15)		2.65	3.00
Anesthesia						
Infiltration	1.00	2.00	1.00 (18) 2.00 (14)		1.44	2.00
Block	1.00	3.00	2.00 (22)		1.80	2.00
Gas	3.00	5.00	5.00 (21)		4.61	5.00
Root Canals						
1 root	2.00	20.00	5.00 (8) 10.00 (9)		7.74	\$3 per treat.
2 roots	2.00	25.00	10.00 (6) 15.00 (8)		9.46	\$3 per treat.
3 roots	2.00	30.00	10.00 (7)		11.36	
Cement filling	1.00	3.00	2.00 (27)		1.90	3.00
Cement lining	.50	2.00	1.00 (28)		1.21	2.00
Orthodontia						
Arch appliance	25.00	100.00	50.00 (5)		58.00	50.00
Monthly fee	10.00	20.00	10.00 (7)		11.72	15.00
Hospital or	2.00	5.00	3.00 (14)		3.81	5.00
Night call	2.00	10.00	5.00 (22)		4.34	
Post Operative Treatment		3.00	1.00 (11) 2.00 (11)		1.52	2.00
Impaction	2.50	50.00	10.00 (15)		12.77	15.00

(Continued on next page)

	Lowest	Highest	Most Popular		Average	Basic Fee
Prosthetics						
Vulc. single denture	15.00	75.00	25.00 (9)	35.00 (8)	34.28	40.00
Vulc. upper and lower	25.00	150.00	75.00 (8)		78.30	80.00
Rebase	5.00	25.00	10.00 (10)	15.00 (10)	13.92	15.00
Reproduction						20.00
Condensite						
Single	25.00	100.00	50.00 (14)		56.32	60.00
Upper and lower	50.00	200.00	100.00 (14)		108.20	120.00
Partial per tooth up to 5 teeth	3.00	16.00	5.00 (5)		7.07	\$15.00 + 1 each extra tooth
Each clasp	2.00	7.00	5.00 (12)		5.37	6.00
Gold plate	100.00	350.00	100.00 (7)	150.00 (6)	174.00	200.00
Palatal bar (Vulc.)	35.00	150.00	75.00 (10)		60.00	70.00
Lingual bar (Vulc.)	35.00	125.00	50.00 (9)		56.00	70.00
Pal. bar (Cond.)	40.00	125.00	100.00 (8)		79.81	75.00
Ling. bar (Cond.)	40.00	100.00	100.00 (8)		78.20	75.00
Akers, per unit	10.00	50.00	20.00 (10)		21.38	20.00

tently low scale. It is a sign-board which points out the directions a man can take. It is up to him to decide which way he wants to go.

Herewith is the analysis of the questionnaires, giving lowest and highest fees noted, the average—and, a number of

men agreed on a specific fee, this is given as the "most popular fee." The last column gives the basic or "yardstick" fee. This scale is frankly an experiment. Let's fight over the items until we get the differences all straightened out. Where do you think our scale is wrong?

Medical Arts Building  
Charlotte, North Carolina

It would be interesting if dental societies in other cities and towns were to compile fee tables in the manner described by Doctor Fox. ORAL HYGIENE will be glad to hear from any who do.



# Writing Without Hands

By M. E. HOPKINS

"HOW'S the writing coming along these days?"

"Not so badly considering everything. Take a look for yourself."

I stepped to the bedside where I could see the writing on the paper which was clamped to the board in front of Elmer Westley, who with the assistance of his dentist, Dr. Russell B. Mosier, has worked out a small device which enables him both to read and to write, although he is paralyzed and has no use of his hands. The writing was surprisingly good and perfectly legible.

Mr. Westley first tried to get a friend to whittle out a wooden pencil holder which he could hold in his teeth, but this did not work well, owing to the fact that he could not "get his teeth into it." Then he called in Doctor Mosier and they planned the device shown in the illustrations.

Doctor Mosier made an impression of the patient's mouth,

and then worked out a wax model of the device to hold a hexagonal pencil. He next prepared a cast from this model in which he molded the vulcanite. The operations after the wax model was made were those ordinarily followed in making dentures.



The tube that holds the pencil has two slots sawed longitudinally in the sides after the vulcanite molding was finished. These slots give enough flexibility to the tube to make it easy to insert or withdraw a pencil.

A hexagonal pencil was used to give greater rigidity. Also, because the patient's teeth fit exactly into the mouthpiece, the device is easy to control and direct when writing, or turning pages.



# RESULTS from a School Program

By IDA MAE STILLEY

WHEN the dental hygiene department of the Brentwood Public Schools was started in September, 1930, 894 children, ranging from six to sixteen years of age, were in attendance in the first through the eighth grade. Of this group approximately fifty children owned toothbrushes, and only half of this number used them for more than an ornament or a souvenir.

It was, obviously, my first task to make the children "unconsciously dental conscious." To that end toothbrushes were bought and sold for ten cents each, and contests for clean teeth were started in each room. I found that a visible, tangible sign, such as a white tooth with a star on it for 100 per cent clean teeth, or a black tooth for unbrushed teeth, was effective in the lower grades. Rarely did the same child forget to



*Miss Stilley and one of her young patients.*

brush his teeth two days in succession. In the upper grades, of course, these methods were not so popular. However, pride was the important factor with the older girl and boy.

Naturally, each child had to be taken to my dental office for examination and treatment. It is astonishing how poisoned many children's minds are against any such operation, and the fault lies either in some previous unpleasant experience or in the stupid talk of some ignorant individual.

Hence, the next step was to gain the confidence of each child, for I had to examine each one. To do this, I determined first of all not to hurt anyone. Then I tried to make my office attractive. I was fortunate to have a room full of sunshine, which I tried

to keep spotlessly clean. I hung interesting health posters made by the children themselves on the walls. On my desk I had autographed photographs of Leon Janney and Mitzie Green, two popular juvenile movie stars, whose teeth are very straight and white, and seemed to offer an added incentive for some to make their teeth better.

On his first visit a few minutes was given each child to adjust himself, and talk to me about anything that I thought might be interesting. The operating chair, raised by a crank, made a lovely "elevator" that stopped at the "floor" most desirable to the patient. Girls usually stopped at the "doll department," and boys favored the "sport shop."

My dental engine took wings and became an airplane, in which one might fly to see a grandma or an aunt. My water syringe became a water gun

used to wash out tooth paste that tasted and smelled like chewing gum. Then there was that lovely tickling sensation, when the rubber cup touched the gum—and we didn't care if it did cause laughter.

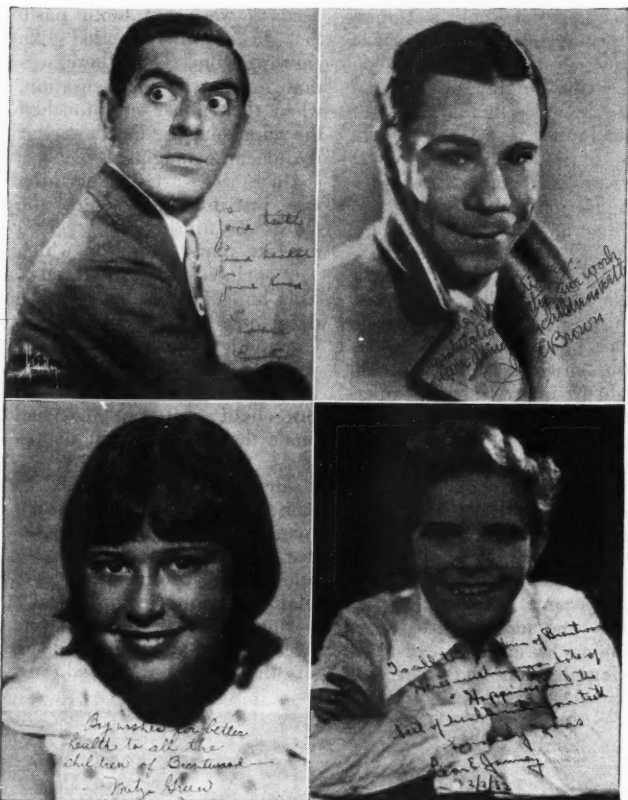
Once we started everything was just fine, and when the child was finished he received a white paper tooth on which was printed "Clean Teeth." This hung from a button on a dress or suit for several days. One mother told me her seven-year-old daughter cut out similar teeth and hung them on pre-school children and had made them think about dentistry!

The lower grades ceased to cause trouble, and it was not long until the higher grades became ashamed of dirty mouths and became prouder than ever of lovely white teeth.

But now that the teeth had been cleaned and the confidence of the children gained, my

*The winners in the Perfect Teeth Contest.*





*Movie celebrities' photos, autographed to Miss Stilley's pupils, help to make the work more interesting.*

work had to center about securing more complete dental care, for my charts and statistics certainly showed the need of immediate attention.

The first move in my new campaign was the distribution to the parents via the child of

cards advising that certain corrections in the child's mouth and teeth be made. The first section of the card recited the importance of good strong teeth and the difficulties with this particular child's which kept them from being healthy. It

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TABLE SHOWING WORK OF DENTAL HYGIENE DEPARTMENT  
BRENTWOOD PUBLIC SCHOOLS

CLASSIFICATION	I	II	III
	Sept. 1930 to June 1931	Sept. 1931 to June 1932	Sept. 1932 to June 1933
Sets of teeth cleaned.....	894	928	745
Corrective advice cards sent home.....	826	526	321
Corrective advice cards returned.....	371	446	135
Cavities in permanent teeth.....	2400	996	398
Cavities in deciduous teeth.....	697	256	243
Extractions of permanent teeth.....	272	197	63
Extractions of deciduous teeth.....	779	438	223
Abscessed teeth .....	82	48	26
Charity cases .....	68*	150†	0
100% teeth .....	58%	91%	74%

\*Paid for by the Brentwood Civic Club. The patients were assigned to various local dentists who did the work just as cheaply as the case would permit.

†Paid for by money collected by the borough Parent-Teacher Association and the Girl Scouts, by contributions from several citizens, the proceeds of a faculty basket ball game and benefit movies, and out of school milk funds.

also requested the cooperation of the parents in making possible a correction of these faults.

The second division was designed for the purpose of discovering the attitude of the parents. It asked: "Will you take your child to the dentist? If so, what dentist? If not, why not?"

In many cases the interest displayed by the child in telling of his teeth-cleaning experiences at school influenced the parents to acquiesce more readily to having the child visit the dentist.

The most common reason for refusing was the fact that the child had "only baby teeth and they would fall out anyway." Whenever I received a card with this reply I immediately had a talk with the parents, either by telephone or by calling at the homes. I found that after the importance of "baby" teeth was clear to them they would almost invariably take the child to the dentist.

The third section of the card called for the signature of the dentist when the work was completed.

It will be noted in column I of the table shown on page 31 that out of a total of 894 children examined, there were only 68, or 8.6 per cent, who were not in need of further treatment. At the end of the first year of the dental hygiene program the percentage of teeth in perfect condition, with or without dental assistance, rose to 58 per cent. Such a gain was made possible by the co-operation of school officials, teachers, dentists, and—most important—the parents of the children.

Dental health pins and gold stars were offered as incentives and contests and competitions between classes added more zest to the game.

In recognition of the effort the children were putting forth, the Brentwood schools were asked to provide some sort of entertainment for the dentists attending the 1930 Pennsylvania state dental convention which was held in Pittsburgh. "Sells-Health-O-Circus," with a cast of forty children was presented before approximately five hundred dentists. This and several other playlets were presented later to the parents in Brentwood.

At one meeting of the Parent-Teacher Association, I cleaned a set of teeth, besides giving a talk explaining the purpose of my work. These activities seemed to increase the parents' interest.

When the work started in September, 1931, getting the child to have his teeth cleaned



*Dr. "Jock" Sutherland's picture helps to make the work colorful. The Pitt football coach is himself a dentist.*

proved to be an easy task. The first graders were not taken to the office until they had become thoroughly acquainted with me through my appearance in the room on any mission but that of cleaning teeth.

I told them health stories, taught them songs, and had them write stories and poems for me. Some even made health booklets. The favorite poem of the first grades centered around the popular figures of "Pop Eye" and "Little Boy Blue." It reads:

Little Boy Blue, come blow your horn,  
For the children of Brentwood you need not scorn.  
We brush our teeth three times a day,  
For we have learned that it will pay.  
Little Boy Blue eats spinach too,

For he has learned just what to do  
To be tall, and great, and spry,  
And have the strength of the great  
Pop Eye.

After they had learned about me and about the older brothers and sisters having their teeth cleaned, they became anxious to know what my room looked like. With these young children the procedure that had been necessary for all the children the previous year was followed.

Some of the pupils coming for their second examination had not brushed their teeth regularly during the previous year, but the majority of them looked very good. Of course, there were some cases that required professional attention.

In the spring of 1932 the children made posters to compete in the contest which the Odontological Society of Western Pennsylvania held for the children of Brentwood. Many clever posters were made and then exhibited later in downtown Pittsburgh.

We also had room contests for 100 per cent teeth, but this year as soon as the 100 per cent had been reached the class was given a half holiday to spend as it pleased. Several classes visited Carnegie Museum, but the majority voted in favor of picnics in Brentwood Park.

At the close of my second year's work I found that the percentage of teeth in 100 per cent condition had been increased from 8.6 per cent when I finished making my first ex-

amination to 91 per cent at the close of the 1931-1932 school year.

Other statistics for the year are shown in column II of the table given on page 31.

During the year 1932-1933 I did not insist that the child visit the dentist due to the stringent economic situation of many of the parents. In an effort to make up this deficiency and prevent any further destruction in the children's mouths it was decided to install dental equipment in the high school. In January the dental department sponsored a circus and raised \$325 which was used to pay for the equipment. However, our arrangements for having the charity work done were not completed and the children requiring care had to do without for the time being. As shown in the table, our percentage of healthy teeth dropped accordingly. We were not so discouraged as we might have been because everything was in readiness for the following year (1933-1934) and this work is now progressing.

An encouraging achievement of the year was the fact that a Brentwood boy and a Brentwood girl won the honor of having the most perfect sets of teeth in a Perfect Teeth Contest sponsored by the Odontological Society of Western Pennsylvania during Dental Health Week. Approximately 15,000 children attending schools in the country employing dental hygienists were examined.

For the school year ending



in June, 1930, 92 boys and girls in the grades had perfect attendance records for the year. This number rose to 107 by June, 1931; in June, 1932, the total stood at 129; and in June, 1933, 204. I cannot help but feel that the dental attention these children received had something to do with making it possible for more of them to achieve these records. The last figure is perhaps most interesting and encouraging in view of the lower percentage of perfect teeth for that year and the lack of charity work.

One of the sixth grade boys has written a poem telling what he has learned about health and living which I think is so complete that it is worthy of appearing here as a summary of what the children were taught:

#### HEALTH LAND

I come from the beautiful land of health,

Good habits, good foods, and lots of wealth,  
The people are healthy and happy and wise,  
And they live under blue and sunny skies,  
Their rules of health I'll tell to you,  
If you follow them you will look like new.  
Fresh air is needed day and night  
To keep you strong so you can fight.  
The teeth are the helpers that grind your food,  
If you brush them you'll be in an excellent mood.  
You should wash your face and comb your hair,  
And give them the best possible care.  
Your finger nails should be kept "real nice";  
Before biting them you'd better think twice.  
Potatoes should be eaten because they have starch,  
No matter if it's June, September, or March.  
Butter has the useful fat;  
On bread you should put at least one pat.  
Drink water and milk quite a lot,  
But the most important is the sun.  
If you have followed these, your health is won.

### HERE'S A BIGGER PICTURE OF DOCTOR WILLIAMS

In November, ORAL HYGIENE printed on page 1628 an article by Doctor L. W. Dunham entitled "The Beginning of a Great Work." It was illustrated with a photograph of historical interest—never before published—showing Doctor J. Leon Williams in his London garden, "at the beginning of one of his greatest achievements for the dental profession—the carving of the first forms of artificial

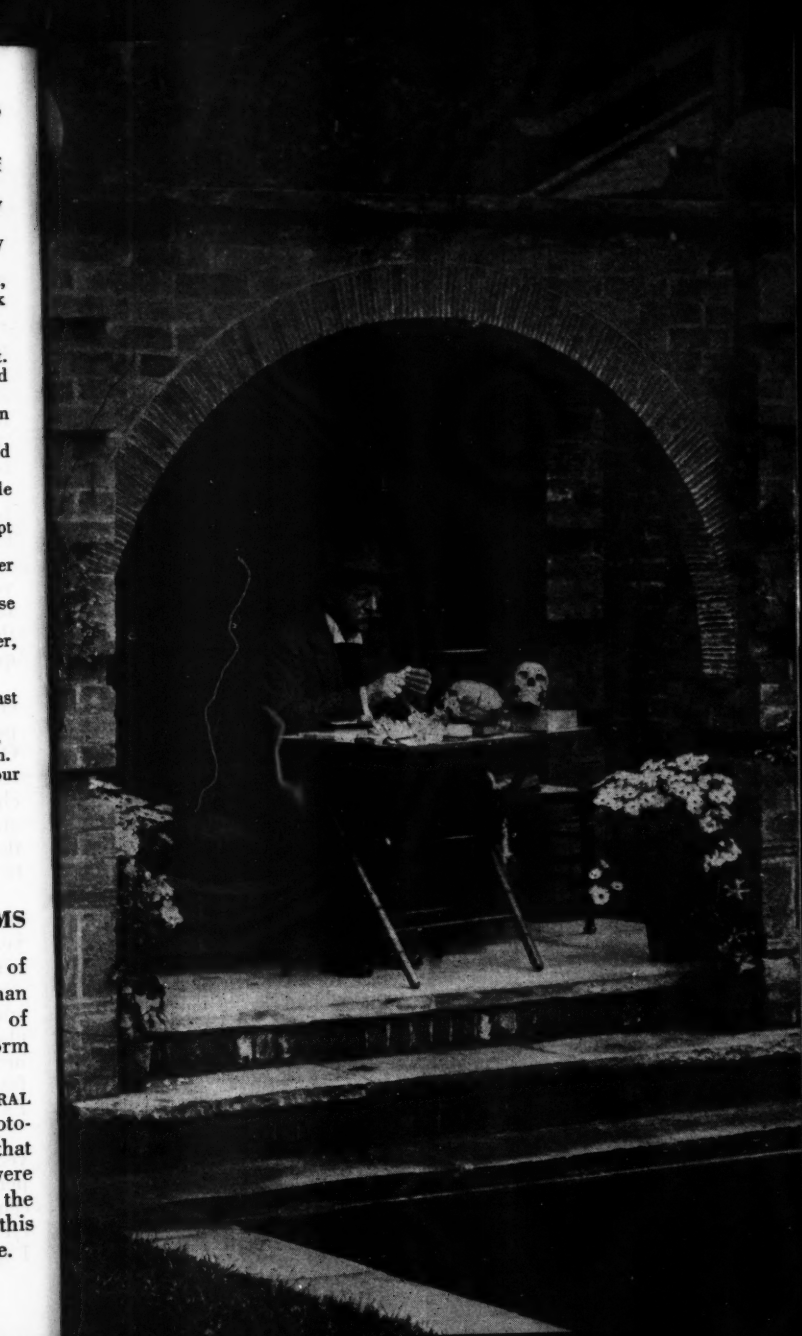
teeth based on his discovery of the three typical forms in human teeth and the principle of harmony between tooth form and face form."

But, thoughtlessly, ORAL HYGIENE reduced the photograph to such an extent that the interesting details were largely lost: therefore, the large reproduction printed this month on the opposite page.

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# HENRIK SHIPSTEAD, D. D. S.

## United States Senator

By FRANK A. DUNN, D.D.S.

**H**ENRIK is a name with a punch. It means *head*, a real head—not head-waiter, elevator man, nor barber like Henry, Harry, Heinie, Hank.

Where you find character you don't always find a Henrik, but where you find a Henrik you do find character. And where you find Henrik Shipstead, D.D.S., United States Senator from Minnesota, you find character plus brain, brawn, and courage. As if these gifts were not enough, listen to this from one of the great weekly magazines: "He is a big, handsome man with personality." And also this from the same magazine: "There is something restrained, almost gentle, in his huge frame that stoops slightly forward at the shoulders as if from meditation." Maybe it was meditation, but it looks as if it might have been due to bending over root canals—or maybe to *pick-ing-up-potatoes*, a pastime to be mentioned later.

But this from another writer is not so good: "The peculiar limitations of his environment

handicap him." That sounds like a sneaked-over jab below the belt on our beloved profession.

Henrik Shipstead was born at Burbank, Minnesota, January 8, 1881. His parents were Swedes. You may be one of those persons who look upon a Swede as a sort of clownish, comic-strip caricature with a yumpin-yimminy dialect. If you are, you are all wrong. A picture of Henrik Shipstead will show him to possess extraordinarily fine features. The same can be said of countless other Swedes, among them the father of Colonel Charles Lindbergh. A famous globe trotter remarked that in his travels through every country on the face of the earth he found the finest looking women to be Swedes. (The writer is not a Swede.)

Here is another quotation from a magazine: "He is young, tall and vigorous with the air of his Viking ancestors."

Vikings were undoubtedly the ancestors of Henrik Shipstead. Viking is a polite word for pirate. And what pirates

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they were! No three point two stuff in half pint glasses for them. They took theirs full strength in what they called horns, horns built like the old oaken bucket or a small tub. Then over the seas they sailed to distant lands. They roved and they roamed, planting camps on the rivers of France, sacking Paris, hammering their foes along the Mediterranean coasts into submission, and gathering gold, jewels, and maidens in abundance. Then back again to the brimming buckets and tubs.

The Minnesota Swedish farmers, of course, were not that type. They hammered fences instead of foes, planted everything except camps, and gathered crops instead of gold, jewels, and maidens. But when their potatoes went wrong or misfortune befell their stock they would show a touch of their Viking forebears. They didn't meekly bend to such burdens with resigned lamentations. They straightened up and they bellowed denunciation of the "Money Power" that by some sort of hocus-pocus had put a blight upon their potatoes or stock. "Money-Power" was the Loki (Viking hoodoo, calumniator of the gods and the contriver and conniver of all fraud and mischief) who brought them bad luck, and the one sure thing to put old Loki on the spot was radicalism. Early in life the growing Henrik had been introduced to radicalism. Radicalism and he shook hands, patted each other

Acme Photo



on the back and began a comradeship that has endured to the present day.

Life seldom turns out a radical masterpiece, physically and mentally. If she gives him a powerful voice, she gives him a puny fist, and if she gives him a big body, she gives him a little mind. But Henrik Shipstead was an exception to Life's radical turnouts. He had the body—six feet of it—developed and toughened on a Minnesota farm. What the usual city man might consider an 8-hour back-breaking job for two men, a lone Minnesota Swedish farmer would do in three hours and look upon it as a mere starter for the day's work.

Telling most dentists about the muscle-straining labors of a farmer is like showing a kangaroo how to jump. But what incomparable training those labors have proved for a vast army in our profession. *Picking-up-potatoes* may sound simple and look innocent, but picking them up certainly strengthened one's back for the long stretches of bending that went with cleaning out root canals. Milking cows seems to suggest something leisurely and gentle, but milking a half dozen cows daily for several months will give one the same bone-cracking, toe-twisting grip used by those modern gorilla-like wrestlers. Then at 7 there was the first and only call for breakfast—there was hardly any need for the first call, to say nothing about a second, because three hours' work had

been done before breakfast. The farmer's day began at 4 a.m. and ended with supper at 6, if everything was all right. If it wasn't all right he might add a few more hours.

These were merely chores compared with the actual farm labors like pitching hay, harvesting wheat, husking corn, building fences (different by far from the way it sounds), and pulling up rocks and roots that left some doubt as to which would be pulled out first, the rocks and roots or the arms.

That was the sort of training that gave Henrik Shipstead his splendid body and hardy courage to tackle and surmount any barriers that might obstruct his path.

His fine mind, of course, was a heritage, which he cultivated intensively. He was in accord with Bacon and while talking maketh a ready man, reading maketh a full man. He filled himself up with reading, reading that was informative and reading that was cultural. He practiced dentistry by day and read books by night—biography, history, science, poetry. He digested the best from the best minds and added his own best, so that when he talked he knew exactly what to say and how to say it.

Minnesota farmers observed Sunday as a day of rest. They would gather for church services, which were followed by picnics. The picnics were the open door through which Henrik Shipstead marched to the

United States Senate. The farmers' idea of a picnic was peculiar—they liked to be talked to for two or three hours. They didn't want pathetically funny stories so frequently told by politicians. They wanted to know what was wrong with the potatoes. Why wasn't wheat higher and why weren't taxes lower? How could the "Money Power" be throttled? They would lend a ready ear to the man who would talk to them on these subjects. Henrik Shipstead was the man to talk to them, at them, with them, and for them. He poured words into their ears for two and three hours at a stretch. He presented plain facts in plain speech.

When a picnicker couldn't quite understand some remark, he didn't sit and ponder but called out for an explanation. Or if a picnicker was in disagreement with the remarks of the speaker he made no bones about saying what he thought and precipitating a discussion, in which Henrik Shipstead would shine because of his thoroughly prepared clear thinking and clear speaking. They liked to heckle a speaker, he liked to be heckled, and so everyone was happy.

He could be ironic, humorous, suave, urbane—but he saved that sort of stuff for other audiences. To the picnickers he was just one of their own kind, trying to solve their problems and lighten their burdens.

All good men have wives, usually. Henrik Shipstead had four: a housewife who could

direct every detail in the conduct of the home; a counsellor who could intuitively and intelligently sense the right thing to do, the right way in which to do it, and the right time; a gracious and charming hostess in social affairs; a campaign manager extraordinary. The four, of course, were all in one Mrs. Henrik Shipstead.

She had a hand—and a heart and head—in those picnics. And she had an ear in them—an ear that had to go through picnic after picnic listening to two- and three-hour speeches. Following a three-hour speech those Swedish farmers could go home, but Mrs. Henrik Shipstead simply moved on to another one.

Devious and rutted, literally, were the roads that led to the exalted office of United States Senator, and Henrik Shipstead traveled them in an old Ford with Mrs. Henrik Shipstead beside him as campaign manager.

In 1916 he was a member of the legislature. Two years later he ran for Congress and was defeated by his opponent, of whom possibly you may have heard, a gentleman named Volstead. But losing never kept down a Henrik. Another two years found him running for the Republican nomination for governor. He lost by only 7000 votes, which was considered a moral victory. These candidates brought him state-wide attention.

In 1922 he was put forward by the Farmer-Laborite party as their candidate for United

States Senator. His Republican opponent was Frank B. Kellogg, a legal luminary of the first magnitude, scholarly, accomplished in statecraft, suave, boon companion of national celebrities, and celebrities not so national. And onto the field to joust with him rode Henrik Shipstead in his little Ford. Frank B. Kellogg arrived in his Pierce-Arrow.

When Jesse Willard laid eyes upon Jack Dempsey at Toledo he probably wished for a flyswatter, and possibly Frank B. Kellogg felt the same way when he looked at Henrik Shipstead, from a political point of view. But undoubtedly, and again like Jesse Willard, his feelings changed as soon as the bout got under way. Frank B. Kellogg purred over the state in his luxurious automobile. With nicely chosen and nicely spoken words he briefly addressed those Minnesota Swedish farmers. Sometimes words go into one ear and out the other but the words of Frank B. Kellogg never even got into one ear of those farmers. Henrik Shipstead rattled around the state in his Ford and sought out those Swedish picnickers. He knew what they wanted and he fed it to them, fed it to them in doses of two- and three-hour speeches. That was the medicine they wanted; it was good medicine in which he sincerely believed—he was the doctor and they were the patients.

Election day proved that not only the Swedish farmers but a vast number of others pinned

their hopes and faith to Henrik Shipstead. He received 325,000 votes, his opponent 241,000. He had the distinction of receiving over 100,000 more votes than the successful candidate for president or for governor, and carried every county in the state.

He has been given the greatest honors and holds the highest office that his state can bestow upon him, and he has proved himself worthy of the honors and the office. Men of his character do not change and he will continue to champion the cause he believes to be right.

What does he advocate? What does he especially condemn in government? What are his views on the war debts? You will have to ask him, and maybe he will come back at you with one of those three-hour picnic speeches.

Apollonia, the patron saint of dentistry, may well be proud of him. He is undoubtedly her most illustrious living son. Many dentists have occupied notable niches in the halls of science and art, but rarely have they entered the halls of statesmanship and world power. Are there not others like him? Aren't there in your dental society *hands that might have swayed the rod of empire* as deftly as they do an excavator or a pair of forceps?

Does he ever look back to the years when he was one of us, arguing with Mrs. Olson or Mrs. Swanson, trying to convince her that her husband's new false teeth did not make



the right side of his face stick out more than the left? To the senior year when he hammered all afternoon on a gold foil filling only to have it fall out on polishing? To the junior year when he held an extracted molar tooth in his hand and poked into the tortuous root

canals wondering how in hell anybody could fill such things? To those early freshman days when some light-fingered classmates could steal his plaster bowls faster than he could steal plaster bowls from them? Or maybe the students didn't do such things at Northwestern.

Rose Building  
Cleveland, Ohio

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### COLYUMISTS' SPOOF TWO WELL-KNOWN DENTISTS

Two well-known dentists were recently spoofed a bit by two newspaper columnists. The anonymous soul who conducts the column "About Town" for the *Kansas City Star* took Dr. Dayton Dunbar Campbell for a brief spin:

"Dr. Dayton D. Campbell is growing a moustache these days with such success as to evoke both complimentary comment and querulous question. 'It adds to your professional dignity,' the praisers say. 'What's the big idea?' demand the critics. To both alike Dr. Campbell explains with characteristic patience:

" 'I'm doing it for my little daughter Patsy. You see, I never have worn a moustache since she can remember. Imagine my embarrassment when I discovered the other day that she was sorrowfully telling her little friends I could not grow one. I'm just proving to her that I can.' "

The other gossip column victim, is Dr. Edward J. Ryan, editor of *The Dental Digest*, and it was really his wife who was "taken for a write." Said Dorothy Dearborn, writing in "Lake Laughter or Scooping the Loop," in the *Chicago Herald-Examiner*:

"The wife of Dr. Edward J. Ryan (editor of *Dental Digest*) had instructed her two small daughters that they give shampoos, one to the other . . . neither shampoo job was successful on first attempt . . . so, when the mother left for an engagement, she told them they would have to do it over again . . . upon Mrs. Ryan's return to the domestic scene, the following was scrawled on the playroom blackboard: NOTICE—MRS. EDWARD J. RYAN is unfair to child labor!' "

# The Practical Consideration of Diet In Relation To Dental Decay

By WAITE A. COTTON, D.D.S.

WHEN we consider diet in its relation to dental decay, we can be sure that such decay is proof of disturbed or changed body functions. It is impossible to conceive that in a body which functions perfectly Nature suffers degeneration of any one organ without involving others. Disease is usually due to some deficiency, either of food, air, water, exercise, sunlight or mental attitude. We believe that deficiencies and wrong combinations of foods with errors in eating form one of the chief causes of disease.

If there is—and we believe there is—a definite control of decay through the right selection of foods and eating them in the right way, then a study of how we are nourished will reveal how the material needed for nourishment shall be chosen and combined. And there is just as much pleasure in good eating as in following the old-fashioned practice of jumbling foods together haphazard, regardless of how they

disagree inside of us and sooner or later make us suffer.

In building a house, it is necessary first to have a design; second, to get the materials, and, third, to have the artisans and tools to put the materials together. The same law rules the building of the human body. Of the twenty odd elements which enter the human body, only five are really needed for the life cycle; namely, hydrogen, nitrogen, oxygen and sulphur. The protein of the cell is composed of these five elements, with two exceptions: in some protein we find a little phosphorus, and in the hemoglobin of the blood we find a little iron. Otherwise these five elements form the living protoplasm. Besides protoplasm, the body needs carbohydrates and fats. These are composed of three of the elements which form protein; namely, carbon, hydrogen and oxygen.

With these five elements forming the basis of the body, the other fifteen are the artisans

Says Doctor Cotton: "If there is—and we believe there is—a definite control of decay through the right selection of foods and eating them in the right way, then a study of how we are nourished will reveal how the material needed for nourishment shall be chosen and combined."

and the building tools which make possible the operation of the five elements. *The mineral salts are the building tools of the body*, for they enter it in fully oxydized compounds and add neither heat nor energy; yet without them it would not be possible to have digestive secretions, osmosis or exchange of material between cells and the blood stream. They also maintain the equilibrium of the acid and base of the body. The vitamins, the inhibitors, accelerators, the catalyzers and the enzymes are the artisans.

All this material must be taken into the body in the form of food, and the food must contain the necessary material in the *right proportions*. In building a house, you would not supply twice as much brick as you need and only half the mortar, nor twice the flooring and only the siding. Neither would your tools be half hammers, nor three-quarters saws, nor forty per cent chisels; you would

supply them in the proportion needed. So in our bodies we must supply all the materials needed and in the right proportion.

#### CONSIDERATION OF FOODS

The five classes of food material should be consumed in the following ratio: fifty per cent carbohydrates, twenty-five per cent fat, ten per cent protein, ten per cent unassimilable matter, and *five per cent mineral salts*. Though the mineral salts are the smallest amount needed, they are the most important, for the functions of the body cannot be carried on without them. I shall not go into a detailed chemical consideration of foods here, but we must have a fair understanding of their nature and the treatment they undergo before being assimilated if we are to understand their relationship to dental condition.

In studying the relationship between diet and dental decay

it is well to consider the different foods and how they digest in the *normal individual*. Then we can see not only how to eat properly but how to avoid eating habits that do us harm.

Foods are of three main divisions: carbohydrates or starches, proteins and fats, each accompanied by its own needful *mineral salts*. We shall consider them in order. First, the starches are divided into three groups: the polysaccharides (starch), the diasaccharides (sugar) and the monosaccharides (glucose and fructose). Commercial starches and sugars as we know them cannot be absorbed into the bloodstream through the intestinal wall, but must be hydrolyzed into a more soluble form for absorption. Starch ( $C_6H_{10}O_5$ )<sub>n</sub> is the symbol used for all starches. Starch will not dissolve in water. It must be split up into smaller molecules before it can be of use to the body.

By the action of enzymes starches are reduced to dextrans, maltose and finally to glucose and other fermentation products. Starch forms a large part of the carbohydrate material needed by the body. It constitutes from half to three-fourths of the solid matter of cereal grains and three-fourths of mature potatoes. In such fruits as bananas and apples, the starch is largely changed to sugar as the fruit ripens, while on the contrary tender young corn and peas contain sugar while growing, which is trans-

formed into starch as the fruit matures.

Digestion of the starches begins in the mouth. As we chew them, they are mixed with saliva. This contains salivary enzymes, ptyalin or amylases, which, mingling with the starch, changes it through dextrin to maltose, sucrose or lactose. The *pancreatic* enzyme also produces the same change—starch to maltose—and the digestive ferment of the *intestinal juice* changes the maltose, sucrose and lactose to glucose, fructose and galactose, which are the only forms of carbohydrates that can pass through the intestinal wall. Acid hydrolysis can also change starch through dextrin and maltose to glucose. This can be done commercially by soaking the starch in about seven per cent hydrochloric acid for several days.

#### DIASACCHARIDES ( $C_{12}H_{22}O_{11}$ )

The principal diasaccharides are sucrose, maltose and lactose. Sucrose or cane sugar is widely distributed in the vegetable kingdom, among the fruits and juices of many plants. It is commercially obtained in the sugar beet, sugar- and sorghum-canes and sugar maple. Many of the common fruits and vegetables contain fair amounts. Sucrose is very easily hydrolyzed by acid or by the sucrase of *yeast* or by the sucrase of the intestinal juice. So far as we know, there is *no enzyme* in the *saliva* nor in the *gastric juice* which will hydrolyze cane sugar. When sucrose reaches

### YOU MAY HAVE A COPY OF DOCTOR COTTON'S CHART

Doctor Cotton has devised a unique nutrition chart which he uses in his own practice to instruct his patients. A copy of it will be sent upon request. Please address Oral Hygiene, 1005 Liberty Ave., Pittsburgh, Pa. Since the chart is printed in three colors it is not practical to attempt its reproduction in the magazine.

the intestine, it is changed by the sucrase of the intestinal juice into glucose and fructose, which is absorbed into the portal circulation.

Commercial sugar eaten in considerable quantities is apt to cause irritation of the stomach wall directly, just as it can cause irritation of a tooth and cause toothache; or it will irritate the stomach as the result of undergoing acid fermentation—or it may be in both of these ways. If refined sugar can irritate a tooth and make it ache, how much more likely it is to irritate and derange the stomach!

Sucrose and maltose ferment more easily than lactose in the stomach. When there is no fermentation and the sugar or sucrose does not irritate, it may be useful as an available food-stuff to create quick energy. However, it is not known that sucrose or cane sugar has any advantage over maltose or lactose, which are less likely to

irritate the stomach or cause indigestion.

#### MALTOSE

Maltose, or malt sugar, is produced from starch by the action of enzymes (amylases), and forms a large part of germinating cereals, malt and malt products. It does not ferment quite so easily as sucrose. In the human digestion maltose is formed by the enzyme ptyalin in the saliva, or by the amylase in the pancreatic juice, which changes the starch through dextrin to maltose. The maltose is further changed to glucose and fructose by the *maltase* of the intestinal juice.

#### MONOSACCHARIDES ( $C_6H_{12}O_6$ )

The monosaccharides are all crystallizable, soluble substances, *not affected* by any of the digestive enzymes. When not attacked by bacteria in the digestive tract, the monosaccharides are absorbed unchanged in the blood stream. The monosaccharides which concern us here are glucose,

fructose and galactose, which are changed in the body, principally in the liver, to glycogen, which is stored up as animal starch.

Glucose, or dextrose, or grape sugar, is widely distributed in nature. It is abundant in fruits and the juices of plants, where it is generally associated with sucrose and fructose.

Fructose, or fruit sugar, is found with more or less glucose in the juices of plants and fruits, and especially in honey. Fructose, like glucose, serves to produce glycogen. Glucose and fructose are easily convertible one into the other by very dilute alkalies.

Galactose, or milk sugar, is the result of hydrolysis of the sugar of milk by the digestive enzyme, *lactase*.

Observe that the hydrolysis of *sucrose* to glucose is accomplished by *sucrase*; of *maltose* to glucose by *maltase*, and *lactose* to glucose by *lactase*. In other words, each diasaccharide requires its own enzyme to reduce it to glucose, fructose or galactose.

When diasaccharides ferment or monosaccharides are attacked by bacteria along the digestive tract, they split up into toxic products and gas which always cause trouble, if this condition continues over a period of time. These toxins put a strain or overwork on other organs and secreting membranes, and the ones that are the weakest will naturally commence to be affected first.

We are no stronger than our weakest organ.

### PROTEINS

Protoplasm, by which the phenomenon of life is observed, is composed of protein, which is the chief organic constituent of muscle and of the cells of plants and animals. It has the same carbon, hydrogen and oxygen as is contained in the carbohydrates, with sulphur and nitrogen added. Without protein there is no life. Plants make their own proteins from the organic material found in soil and air. Animals and man form their protein from the protein of plants and flesh, and each individual produces protein that is characteristic of that particular individual. Man cannot make protein from inorganic substances as the plant does; therefore he must obtain all his protein from the vegetable and animal kingdom; and proteins are necessary to support the life of all animals and men.

As starch on hydrolysis yields the polysaccharide dextrine, the diasaccharide maltose, and finally as end product the monosaccharide glucose, so native protein is hydrolyzed through peptones, polypeptids and di- or tri-peptids, to amino acids. Thus the amino acid bears to the protein the same general relation that glucose bears to starch. Starches on complete hydrolysis are all alike in that they yield glucose, while proteins on complete hydrolysis may yield from twelve to twenty

ty of the amino acids. All proteins must be reduced to amino acids before they are absorbed into the circulation.

#### FATS

Fats, too, are composed of carbon, hydrogen and oxygen, and can be built up in the body from carbohydrates, though their composition is quite different from carbohydrates. They are made up of about one

part glycerine ( $C_3H_8O_3$ ) and nine parts of a fatty acid ( $C_{18}H_{34}O_2$ ). There is no digestive *secretion in the saliva* which will affect fats, and there is no *enzyme in the stomach* which will affect fats. In the intestine the enzyme lipase converts fats to a fatty acid and glycerine before they can be assimilated.

*(To be concluded next month)*

241 West 71st Street  
New York City

### THE CHICAGO DENTAL SOCIETY

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# **"Why Doesn't Dr. Dean Learn Nerve Block?"**

*By* JOSEPH B. JENKINS, D.D.S.

**T**HE telephone shattered the customary stillness of the dental office, and the startled assistant sprang from the comfortable depths of a reception-room chair to answer.

After a moment she turned and gravely announced, "Doctor, it's a lawyer, wishing to speak to you, personally."

Sensing trouble at the word, "lawyer" the dentist took the receiver and answered. A crisp voice announced, "This is Mr. Courtney speaking. I have a client in my office who has brought a suit for damages against Doctor Dean. Is he a friend of yours?"

"Not especially. Every conscientious dentist is a friend of mine."

"I called to know if I could

use you to testify against him in this case. Here are the circumstances: My client went to this dentist and had an abscessed tooth extracted. It swelled up and he had a long siege with it. Soon after this he developed a skin eruption and a painful type of rheumatism which he believes, and his physician says, was probably caused by the extraction of this abscessed tooth. Could I get you, as an expert witness, to say that this abscessed tooth should not have been removed under these conditions?"

Then he added with a touch of salesmanship, "You know, there's a witness fee of \$25 in it, and, knowing you, I thought I'd like for you to have it."

"I appreciate your remembering me, but I could not be of

**"In the name of truthfulness and fair play . . . let every dentist who does not practice genuine nerve block anesthesia call his injection by its right name."**



*"None of that for me. I had that done once before."*

much help to you as a witness, but," the dentist added with a show of spirit, "I would be glad to serve as a witness for the other doctor."

The dentist hung up the receiver, turned from the telephone, and said rather earnestly to the secretary who had heard only one end of the conversation:

"In this community, as in every community in this country, there are dentists who are almost daily laying themselves liable to prosecution for violation of the law for obtaining money under false pretenses.

"Any man who infiltrates the gum tissue about a tooth and calls it nerve block, block anesthesia, blocking the nerve, or deep nerve blocking deceives

the patient, and lays himself liable to prosecution for obtaining money under false pretenses, as much so as one who pays a blind man a five-dollar bill and calls it a ten. That is about what has happened in this case."

"Why doesn't Doctor Dean learn nerve block?" the secretary asked.

"He is in one of the four classes of dentists who cannot or do not do nerve block anesthesia. These classes are: first, those who have never made an effort to learn it; second, those who have not the degree of intelligence to learn it; third, those who prefer general anesthesia to nerve block; fourth, those who are excluded from postgraduate classes in

nerve block because of questionable practices and unethical conduct.

"Those who have never made an effort to learn it are either too careless or indifferent to the needless and preventable suffering of their patients to bestir themselves and acquire the science which their patients have a right to expect. They are also overlooking a powerful factor in practice-and-income building. Such men ought to wake up.

"Those who have not the necessary degree of skill and intelligence to master nerve block should either confine themselves to those departments of dentistry not requiring anesthesia, or associate themselves with men who can do it.

"The third class—those who prefer general anesthesia—are frequently men who are not adept at nerve block, or who have access to an expert anesthetist, and are expert operators under general anesthesia, believing sincerely in the superiority of general to local anesthesia. Occasionally one of this class of men defends his judgment by disparaging block anesthesia, enlarging upon its disadvantages. Such tactics are detrimental to the public and injure the profession.

"The fourth class—those who are not permitted to enter classes of postgraduate instruction in nerve block—are usually excluded because of unethical practices and unfair tactics of competition, and so attempt to offset these lost privileges by

soliciting patronage through public advertising. Knowing the public appreciation of block anesthesia, they frequently ride upon this wave of popular favor by calling their unscientific practice nerve block, and charge accordingly.

"Any dentist who through carelessness, indifference to human suffering, or inability to learn anesthesia, selfishly misrepresents the merits of block anesthesia, and needlessly hurts the patient, hurts not only the patient but hurts his own practice, and the practice of every dentist and the general public. The patient remembers the painful experience, and stays away from such an office until driven there again by a greater pain. He tells his friends about his unpleasant experience and they also avoid that and similar offices as long as possible, thereby inducing procrastination and dental neglect which are reflected to at least a small degree as a lowered dental appreciation and patronage, relative higher overhead and a lessened income for the dentists, and necessarily higher fees to the public.

"A patient requiring the extraction of a tooth goes to the office of one of these men naturally desiring a painless operation, but not wishing to submit to a general anesthetic. The dentist offers to block the nerve, takes a hypodermic needle, infiltrates the soft tissues about the tooth and removes it with a degree of painlessness and asepsis varying

with the physiological conditions of the associated parts, and the density or porosity of the cortical plate of bone overlying the tooth.

"If dry socket follows, or if the tissues about the tooth were in a certain stage of inflammation, the stasis of circulation prevents dissemination of the anesthetic solution with its obtunding action upon the nerve, and the extraction is naturally, not *painless*, but *painful* before, during, and after. If there is a condition of suppuration present and the needle invades this region, and if the solution is forcibly injected, the protecting leukocyte wall around the invading infection may be broken down and the infection thrown directly into the blood stream, exactly as if it had been shot into the tissues with a hypodermic. Pain and serious complications frequently ensue, and "nerve block" gets the blame. This is about what has happened in this case. Let this patient go to another dentist who offers to block the nerve, and he will be told:

"No, sir! None of that stuff for me! I had a dentist block the nerve for me once, and it hurt me like Sam Hill for days. Never again!"

All too frequently dentists are summoned as witnesses in

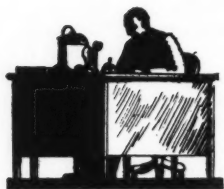
damage suits wherein the patient seeks to recover alleged damages from the dentist. The "unsterile instruments" claim seldom stands up in court since it is easily established that there is usually more sepsis habitually in the human mouth than could possibly have been carried into it by a dental instrument, much less one that has been scrubbed and boiled since use. The dentist-witness usually knows, in reason, that the dental complications and injury could be traced to a so-called nerve block, but, for the protection of all dentists, he is compelled to refrain from such testimony, thus permitting the reputation of nerve block to suffer another blow in the public mind.

In the name of truthfulness and fair play, and for the protection of all concerned, let every dentist who does not practice genuine nerve block anesthesia, call his injection "local anesthesia," "infiltration," "freezing the gums," or anything else he may choose, but never call such procedure "blocking the nerve," lest some day the legal profession get wise to it, and change its favorite claim for damages from "malpractice" to "obtaining money under false pretenses"—and make it stick.

Medical Arts Building  
Oklahoma City, Oklahoma

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*Coming—"The Law and the Dentist"*



# BROTHER BILL'S LETTERS

*Series IV - No. 5*

*By GEORGE WOOD CLAPP, D.D.S.*

**M**Y dear John:  
On Wednesday morning there came to your office a lady who set you all a-flutter. When she had been sitting in the chair for a few minutes, you came to where I was and told me that she was Mrs. Prom, a leader in some of the best social circles in the city, and that if you could get her for a regular patient, it might be very advantageous to you. You had asked permission to present me and she had consented. You then gave me a very flattering introduction and I took my usual place, at the

left and in front of the chair.

You made what seemed to me like an extremely superficial examination of her mouth and said, "You need to have your teeth cleaned and polished, and you ought to have those missing teeth replaced."

"Very well," said she, "I'll call up some day and make an appointment for the polishing. I won't do anything about the missing teeth now. They are only back teeth anyway, and nobody can see them." And with that she started to leave the chair.

While you had been examin-

ing and talking, I had been studying Mrs. Prom. She was apparently about 50 years of age, in good general physical condition, of good intelligence and very decisive. Evidently her husband had made some money and she enjoyed the social position it made possible. From what little I could see from where I stood, it seemed that her mouth was, so to speak, "crying for service," that you didn't perceive either her need or your opportunity, and that she was about to be lost to you. I decided to try an experiment, so I said, "Mrs. Prom, would you think it impertinent if I made a suggestion?"

"No, indeed," she replied. "What is it?"

"It is too bad you are permitting old-age changes to come into your face so many years before their time. If you will pardon my saying so, you are an unusually good-looking woman, and I think that, with proper care of your face, you might stay so for a long time yet."

"What are those changes and what do you mean by proper care of my face?" and her tone was very different from the light and even flippant way in which she had just dismissed my suggestions.

"Do you mind if I examine your mouth more closely than I can from here?" I asked.

"Certainly not. Examine it as closely as you like. If you have anything worth while to suggest, I want to hear it."

I asked you to get Mrs. Prom

a hand-mirror, so that I could point out to her own vision certain things. You had not discovered that a hand-mirror is an extremely important part of your educational equipment and had to make a rather long search for one. Always have a mirror handy. Let it be of good size, of the best possible glass and heavy so that the patient will soon tire of holding it up in your way.

While you were searching for the mirror, I found the following conditions:

Her upper anteriors were present, but the upper posteriors were gone back of the second bicuspid on the left side, with the exception of a small and frail-looking third molar not in good position. On the right side the second bicuspid and the molars had been gone a long time. The lower anteriors were in place, but the bicuspid and one molar were gone on the left side, and one bicuspid and all the molars were missing on the right side. Firm pressure forced a little pus from around two teeth. She and I had quite a dialogue, something like this, as I recall:

"Please look in the mirror. Weren't your front teeth formerly close together?"

"Yes. That little space between those two big ones has come only the last year or two."

"Do you see that the corner of your upper lip on the right side is beginning to stand out just a little as compared with the left side?"

She studied that for quite a

while, moving her lip and bringing it back to rest, before she said, "I hadn't noticed it, but I think I see what you mean."

"Now please hold the mirror directly in front of your face and look at both cheek lines about an inch in front of the ears and compare one side with the other." I traced the line lightly down the cheek on one side to focus her vision. "Do you see a difference?"

She looked a long time before she answered: "I'm not sure. If there is a difference, I should say the right cheek was a trifle flatter than the left. I suppose the two sides of the face differ somewhat anyway. Does that mean anything?"

"I think I can show you that these things are the forerunners of important changes which will be very unwelcome to you. They are coming on so gradually and painlessly that you are unconscious of them, but I'll wager some of your eagle-eyed friends see them, especially when you are tired, and they may say among themselves, 'Mrs. Prom's beginning to look old, isn't she?' That cheek is beginning to sag a little. By and by it will have a baggy line along the jaw, and that deformity is probably beyond correction."

I asked you, John, for plaster casts of a good natural dentition, but you seemed to be unaware that patients can't visualize these things as we do and you hadn't any, so I had to get along without them.

"The back teeth you have lost," said I, "were large, strong teeth and they came together almost end to end," and I illustrated by doubling my fists and fitting the knuckles and backs of the fingers together. "They took the force of the jaw each time it closed. If you were eating the kinds of food you should and chewing them as you ought, your jaws would come together at least 4000 times a day with a total force of between 10 and 20 tons.

"The teeth you have left are not of the form or position or size to withstand that much force without destruction. Your lower front teeth are driving your upper front teeth forward and apart. That is what is making the space between the two large upper front teeth. Unless you stop it, this space will get steadily wider. What you would call your 'eye-tooth' on the right side is being forced forward, and that pushes out the lip.

"The teeth are supported by a rather thin bone, which is strong enough when the teeth are properly used, but it cannot withstand the kind of abuse you are giving them. Your gums are being destroyed and the hold of your teeth will be loosened. These conditions will get steadily worse unless you take the matter vigorously in hand very soon. They will constitute an unpleasant deformity, and, as the condition is likely to be beyond remedy, it will be



the source of long and serious regret."

"Why hasn't some one told me these things before?" said she, and nothing was farther from her mind now than flippancy.

"Perhaps you never gave anybody a chance," was the only reply I could think of, but it was instantly shown to be a mistake when she said, "I gave the doctor here a chance, and he never mentioned them."

"He is many years younger than I am, and the perception of these things and their serious consequences comes only slowly as the result of long experience," was the only defense I could summon.

"My husband is away all day at business," said she. "The children are married or at college. I get a great deal out of my social life, and I intend to keep on doing so. My face isn't my entire fortune, but it's a good deal of my social fortune, and none of the things you have suggested is going to happen to it if I can help it. What am I to do, and how and when am I to do it?"

This inquiry was addressed to you rather than to me, but as you did not show any signs of responding, I had to go on. So I asked several questions as to her social life and then said: "If you were my patient, I should make it very plain that while the dentist can do a great deal to prevent increase of this deformity and might even correct a part of what has occurred, ninety per cent of the

responsibility and work rests on you, and if you are not willing to undertake it, you will get very much less of a success than is desirable. I think your physician should work out a diet for you that will give these bones a chance to recover their health and endurance, but it will be mostly of fruits and vegetables and it will be very embarrassing to you at many social dinners."

"We haven't any physician. My husband and I are old-fashioned. We take senna tea three times a week, and we haven't had a doctor in five years. Suppose you suggest what I should have for a diet. Don't worry about the social affairs! I've always done as I thought best, and I can keep right on. None of my kind friends is going to get a chance yet a while to say, 'Mrs. Prom's beginning to look old.' [I had thought that would register.] What else?"

"I should want you three times a week for a month or so for prophylactic treatments, twice a week for perhaps another month and after that as necessary, but probably about once in sixty days indefinitely."

"What about these missing teeth and this damage that's going on?"

"They will have to be replaced in such way as to take the strain off the front teeth, to restore the length of face and to fill out the cheeks as they should be. If you can build good bone fast enough by proper diet, you may not have

to have the plates remade more than once for quite a while. If you cannot build the bone, they will have to be remade frequently and will be troublesome and expensive."

"What will all this cost?" said she.

"I can't tell you, because this is not my office. I suppose the regular hourly fees for service. No one can tell in advance what it will cost to replace those teeth as they should be. After models have been made and well studied, I could give you an approximate fee, which I should not expect to exceed." And with that I stepped out of the picture and let you talk.

"Never mind the money then." She reached in her purse for a little social appointment book. "Can you see me on Monday, Wednesday, and Friday mornings at 9:30?" she asked, and when you said you could, she entered her appointments for three weeks. "We will take the other things up as we come to them," said she, and after bidding us a cordial farewell she went out.

We had spent more than an hour in talk and it was lunch time. You thanked me profusely for what I had done and said you thought I had solved your problem. If Mrs. Prom should get you into her circle, you would be, as you said "fixed" for the rest of your professional life. You told Mildred about it at lunch, and she was as happy and enthusiastic as you were. We played golf that afternoon and you could hardly have hit

the ball with the bag, to say nothing of anything so small as a club.

Now, here is the pitiful part. Not a word that you said that day or during my stay showed the slightest comprehension of the numerous difficult and intricate problems which you need to solve for Mrs. Prom. I hadn't solved your problems. I merely took the one step of presentation to the patient, which you should have been able to take years ago. I had set you down in the midst of a group of problems I don't believe you know exist.

If you are going to get into Mrs. Prom's group and stay there, you will have to earn your way on your merits, not on hers. Any work you do in Mrs. Prom's mouth will be beneficial to her, but I am quite sure you will not do for her or even perceive the things which would make her your enthusiastic supporter and which would, as you said, "get you in with her crowd."

I believe your knowledge of prophylactic technique is elementary. When her mouth is ready for impressions, the best possible technique is indicated. You will probably take very ordinary impressions, send them to the laboratory and expect the laboratory to design the pieces. If you do that, you will turn your back on every important opportunity this case offers. You have here tissues not capable of sustaining much stress or wrongly directed stress. You have abutments

which must be protected from excessive strain. The movements of the two sides of the mouth are probably quite unlike. It is important to the success and durability of the restorations and to your reputation that these partials should be set to carefully balanced occlusion. What do you know about balanced occlusion in a mouth with asymmetrical lateral movements? If you don't know how to find out what is needed, how can you expect the laboratory man to construct the pieces that should be required?

If your conduct during the last two years has been anything like what it was during

220 West 42nd Street  
New York, New York

my visit, you have wasted enough time to have mastered all the technique this case and others like it will require.

No one but you can solve your problems. No one else can give you the knowledge and skill to "get you in with Mrs. Prom's crowd" and keep you there.

The most hopeless feature of the entire situation is that you seem to be entirely unconscious of this inescapable responsibility and what it imposes on you, and of the great opportunities it offers.

Yours,

Bill

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### DENTAL DIGEST ARTICLES FORECAST

*The Dental Digest* has announced a number of feature articles for coming issues, including:

Diet and Dental Caries; the Dental Pulp; Syphilis of the Oral Mucosa; The Management of Class V Cavities; Efficient and Compatible Orthodontic Appliances; Cleansing of the Teeth; Common Cysts of the Jaw; Common Causes of Failure of Mandibular Block Anesthesia; Clasp Design; The Dentist and Tuberculosis; Sanitary Bridge Technique; Extraction in the Treatment of Malocclusion; Ethyl Chloride Anesthesia for Children; Hemorrhage; Infected Sockets; A Simple Occlusal Inlay Technique; Surgical Diagnosis; Amalgam; How a Dentist May Make His Own Clinical Motion Pictures; Space Retainers; Post-operative Canal Filling in Apicoectomy; Microscopic Technique for General Dental Practice; The Problem of Close Bites and Doubtful Abutments in Fixed Bridgework; Moulage.

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### ORAL HYGIENE ANNUAL INDEX FOR 1933

The Annual Index for 1933, in pamphlet form, suitable for binding with 1933 issues of ORAL HYGIENE, will be sent upon request. Please address Oral Hygiene, 1005 Liberty Ave., Pittsburgh, Pa.



W. LINFORD SMITH  
Founder

# ORAL HYGIENE

Editorial Office: 708 Church Street,  
Evanston, Illinois

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## AN ANNOUNCEMENT BY THE PUBLISHER

IT gives me a great deal of pleasure to announce that Doctor Edward J. Ryan has accepted the editorial directorship of Oral Hygiene Publications—including ORAL HYGIENE itself, *The Dental Digest*, and *Spanish Oral Hygiene*.

Doctor Arthur G. Smith has retired as editor of ORAL HYGIENE with our best wishes and our appreciation for his many splendid contributions to the magazine's pages.

As for the new editorial director, he certainly needs no introduction at my hands. He is well known as treasurer and a director of the Chicago Dental Society.

And his brilliant work the last two years as editor of the new *Dental Digest* has been the subject of enthusiastic comment by members of the profession the country over.

As its thousands of readers know, that

magazine has made journalistic history during the past twenty-four months. And to Doctor Ryan belongs the lion's share of the credit for the achievement.

When he became editor of the new *Dental Digest*, he took what might be termed the dim blueprint of an idea and patiently, skillfully, built it to reality in the form of a magazine which has won the profession's enthusiastic admiration and respect.

Needless to say, each magazine will retain its separate and distinct identity. ORAL HYGIENE will continue to deal with the intimate, human problems of dentistry, to reflect dental life. *The Dental Digest* will continue to treat the profession's technical problems, in brief text profusely illustrated.

So ORAL HYGIENE will continue to be ORAL HYGIENE. Doctor Ryan plans to preserve intact the journal's unique and individual and unconventional character—to improve it by intensifying the qualities which have made ORAL HYGIENE unlike any other dental paper.

He is increasing his staff by the addition of trained personnel and takes over active editorial direction of this magazine with the March issue.

With serene confidence in his ability, the publishers are happy to entrust to him the complete editorial control of ORAL HYGIENE.

MERWIN B. MASSOL, *Publisher*

# AN OPEN LETTER TO DOCTOR MACHAT

Dear Doctor Machat:

Your recent article\* presents the present status of the members of the dental profession as clearly and concisely as I have ever seen it in print. I think no one can deny that your proposals as to the Utopian dental practice are above reproach. But omitting any discussion on the feasibility of assessing and collecting taxes (as you suggest) for financing state dentistry, there remains the almost insolvable problem of non-political administration of such a system.

The unfortunate fact exists that human nature cannot be changed. That sentence explains why no socialistic government differs from any other democratic government, once its advocates get into power. Theories in print or flowing from the mouth of some glib-tongued spell-binder sound beautiful. What becomes of them when put into practice?

I can cite an incident which is an example of this frailty of human nature. In a city of which I have personal knowledge there has for some time existed a large Socialistic population. Four years ago, due

to disgust with the actions of politicians of the two major parties, this Socialistic group secured enough additional votes to place it in control of the city administration. While in office (they were in power for four full years, at least two and one-half of which were during this depression period) they busied themselves with forgetting all of their beautiful Socialistic principles, and instead spent the time feathering their nests and those of their families at the expense of the taxpayer.

That is just one incident, but I think you will find it to be the basis of the failure of any such plan as state-controlled medicine or dentistry; where public monies are gathered you are bound to find the politician getting more than his share.

Your ideas on the inexperience of the new graduate, and his need for closer association with older and more experienced practitioners are, I think, the real basis for solution of the whole problem. Group practices would not only benefit the young dentist, but the public as well. I think I am qualified to speak on that subject, since I am one of those young, struggling, depression-bound graduates.

ROBERT B. LOOS, D.D.S.

\*ORAL HYGIENE, September, 1933, p. 1352.

418 North Tenth Street  
Reading, Pennsylvania

# Greater New York Meeting Draws 5000

THE Greater New York meeting last month enjoyed an attendance substantially larger than the 1932 meeting—indicating rather definitely that the profession's economic status is improving. Many came from distant points to participate in the ninth annual session of what has become one of dentistry's important national events, New York's annual undertaking "For Better Dentistry," staged by the First and Second District Dental Societies.

Clinics, topic discussions, table clinics, essays, etc., filled the five days beginning December 4; Hotel Pennsylvania swarmed with dentists—about 5,000 altogether.

Monday opened with a conference of physicians and dentists, held under the auspices of the Joint Committee of the Organized Medical and Dental Professions of Greater New York. The object was to call to the attention of both professions the close relationship existing between systemic and dental diseases—and to stimulate more interest and cooperation in the care of patients so that the public may receive better service.

Among Tuesday highlights was a series of twenty-three clinics embracing a wide variety of topics, held during the morning. The afternoon was devoted to pathodontia and prosthodontia section meetings. That evening Doctor Russell W. Bunting of the University of Michigan discussed "The Present Status of Our Knowledge of Dental Caries." Covering briefly the various lines of research which have been directed at a solution of this problem, Doctor Bunting detailed the results of the Michigan group's work. He also submitted evidence supporting the view that dental caries is a bacterial disease dependent upon many local and systemic factors. Lantern slides illustrated his essay. Doctor Bunting was followed by Doctor Bert G. Anderson who explained Yale's medico-dental program.

On Tuesday morning, prior to the clinic session, Miss Ferol Rudd gave practical talks on dental office efficiency and practice management. Miss Rudd also spoke Thursday morning. Her first meeting, in the small ball room of the Pennsylvania, was presided over by Doctor Lester B. Dunning, vice presi-



dent of the Second District Society.

Wednesday was Branch Society Day, and nine members presented clinics. A number of registered clinics took up the rest of the morning. At noon the Alumni Luncheon provided

a pleasant interlude. Doctor A. C. Wherry, president of the American Dental Association, was guest of honor.

In the afternoon, two speakers were featured, Doctor George



Wood Clapp and Doctor Harry Bear. Doctor Clapp told "How the Public is Selecting Dentists." He stressed his belief that during depression the public has divided dentists into two groups and is patronizing one

group more than the other. This, he said, has made the present condition of one group very difficult—its future uncertain.

The other group, Doctor Clapp asserted, is forward-looking and its future is assured with prosperity's return. He said he thought that patients' selection of dentists can be made to furnish valuable suggestions regarding the conduct of practices in a manner satisfactory to the public. He views as vitally important a new adjustment by the profession to public needs.

Doctor Harry Bear, speaking on "Some of the Mutual Responsibilities of the Dental Specialist and the General Practitioner," dealt with the social and ethical concepts involved.

Wednesday evening was given over to topic discussions, described as "clinic sessions without clinics." Various topics were covered, including an interesting discussion on children's dentistry, over which



*Beginning on opposite page, left to right—Doctor M. C. Winternitz, dean of Yale School of Medicine; Doctor S. W. Wynne, health commissioner of New York; Doctor Theodor Blum, president of First District Dental Society; examining specimens of phosphorus and calcium at the Vitamin D display which was part of the Health Exhibit.*

Doctor Waite A. Cotton presided, with Doctor Russell W. Bunting as leader. Discussions for hygienists and assistants were held the same evening.

Thursday morning another large group of registered clinics was presented. Thursday afternoon the featured essayists were Doctor Thaddeus P. Hyatt, Doctor Arthur H. Merritt, Doctor Robert H. Ivy, and Doctor Walter F. Barry.

Doctor Hyatt's paper was forecast as a "bombshell." He stoutly defended the old belief, lately disputed, that "a clean tooth doesn't decay." He challenged to public debate any who disagree with his theory that "the free acids of the mouth do not cause decay, the free bacteria do not cause decay." He emphasized his conviction that "the undisturbed retention of food débris, carbohydrates, and bacteria is essential for the beginning of decay." Doctor Hyatt directly opposed the findings of such men as Doctor Russell W. Bunting, who had spoken earlier in the week on the nutritional control of dental caries.

Doctor Hyatt said there was ample support "for the conclusion that dental caries always begin on the outer surface of the tooth," and that when the surface is properly protected the tooth will be preserved against caries. He stressed his belief that "those parts of the tooth which, either by mastication, or careful mouth toilet are kept free from the undisturbed retention of

food débris and bacteria do not, never did, and never will decay."

Thursday evening was devoted to table clinics and the session of the New York Section of the International Association for Dental Research, over which Doctor Milo Hellman presided.

Friday morning thirty-one dental manufacturers presented clinics in the Grand Ball Room.

During the week exhibits were maintained by the New York Institute of Clinical and Oral Pathology, displaying case histories, and by the Murry and Leonie Guggenheim Dental Clinic School for Dental Hygienists. The latter exhibit showed the effect of dietary fluorine in rats, and variations in salivary protein.

The Health Exhibit was also continued throughout the week under the direction of Doctor W. F. Spies and Doctor Clyde M. Gearhart.

In gathering the material for this exhibit, the aid of the experimental nutritionist was elicited for his studies in the field of dental nutrition. Some of the experiments—according to the sponsors of the Health Exhibit—suggested that dietary factors may supply the defensive means with which teeth and gums resist bacterial invasion.

Others showed that if the diet did no more than conserve normal digestion and function of the digestive tract, a great step forward has been made

toward the prevention of tooth destruction.

It therefore (stated the Health Exhibit sponsors) becomes essential for the dentist to study nutrition to learn what food factors are concerned in tooth building and maintenance of tooth health so that he may properly advise his patients. Also, they said, the dentist should study the dietary factors which reduce the power of mouth germs, control their kind, and produce healthy gums.

Health exhibits were contributed by Doctors Russell W. Bunting, Percy Howe, Walter H. Eddy, George Wood Clapp, L. M. Waugh, H. J. Leonard, H. C. Sherman, H. D. Pease, C. L. Drain, C. N. Frey, E. C. McBeath and Theo. Milton Hanke.

Doctor John T. Hanks was

honorary chairman of the Greater New York December meeting, with Doctor Carroll B. Whitcomb as chairman and Doctor Clyde H. Schuyler as treasurer. Committee chairmen were: Doctor Glenn H. Whitson, essays; Doctor Jerome H. Tryer, clinics; Doctor Waldo H. Mork, registration; Doctor Clyde H. Schuyler, topic discussions; Doctor C. M. McNeely, publicity; Doctor C. Raymond Wells, entertainment.

Next year the Greater New York December Meeting will celebrate the centennial of organized dentistry in New York, the first society having been founded in 1834. A centennial commission is already at work on plans for the hundredth anniversary and will offer prizes and medals for papers. Next year will also mark the tenth anniversary of the Greater New York December Meeting.

## Dr. Clapp Takes Issue With Dr. Hyatt

Following the Greater New York meeting, Doctor George Wood Clapp took issue with Doctor Thaddeus P. Hyatt's theories in a letter published in *The New York Times*:

### DIETING FOR HEALTHY TEETH

*To the Editor of  
The New York Times:*

THE TIMES carried a short summary of an address by Dr. Thaddeus P. Hyatt, Professor of Preventive Dentistry at New York University, who spoke at the recent Greater

New York dental meeting. The gist of the summary was that uncleanness alone causes decay of the teeth, that a clean tooth will not decay and that diets of oranges, tomatoes, cod-liver oil, etc., are of more benefit to the manufacturers of those things than to the patients.

Not many years ago many of us in the dental profession thought and spoke as Dr. Hyatt thought and spoke in that address. But wider experience and observation compelled many among us to change our minds. Even if we permit Dr. Hyatt to limit the intent of the term

"clean tooth" to mean teeth free from what the dentist calls plaques and the public calls "film," there are probably very few clean teeth. Probably 98 per cent of the teeth in human mouths in the United States have film of one kind or another. But millions of those teeth have not decayed, and probably will not. I have seen film on teeth that may have been there fifty years without causing decay.

There are groups of people in parts of the world not yet affected by the great American diet of meat, cooked starches and sweets who live long lives without the dentist, the toothbrush and the dentifrice, and with little or no decay of the teeth. Dr. Boots has demonstrated this among the Koreans, Dr. Gysi amid the shepherds of South Germany and the Swiss mountaineers, and Dr. Waugh among the Eskimos of Labrador and Alaska. Each of these dentists has shown that wherever the American diet enters, decay of the teeth enters with it.

#### RESULTS OF DIET

Dr. Fones, in Bridgeport, Conn., examined with what we call "disclosing fluid," which is designed to cause film to show itself, the mouths of 600 young men, none of whom had visited a dentist or used a toothbrush. The mouths of the 200 young men whose parents came from Northern Italy and adjacent districts could hardly have been more unclean, but the teeth were practically free from decay. The mouths of the 400 young men who had lived on the American diet were ravaged by decay.

The death-knell of the theory to which Dr. Hyatt still clings was sounded for many of us when Drs. Boyd and Drain arrested decay in the mouths of children too sick to have ever had dental service, merely by seeing that the children were well fed. Some of these children had ten cavities each. The debris in the cavities was not touched. Decay was arrested by diet in the midst of all the uncleanness one could ask, and with no effort at cleanliness. The cavities are open, or were the last

I knew, but decay was stopped.

#### ARRESTING DECAY

The flowers at the funeral of the theory Dr. Hyatt advances were supplied by the Chicago Dental Research Club. They found more than three hundred children in a home at Mooseheart, Ill., well fed and well cared for, with habits of good mouth care. Each child had three ounces of orange juice daily. Nearly 80 per cent of the children had active decay of the teeth. The dentists gave each child a pint of orange juice and the juice of half a lemon daily for a year, without changing the habits of mouth care. Decay of the teeth was prevented in some mouths and arrested in half of the children who had it. At the end of a year the quantity of orange juice was again made three ounces per day. Before another year had passed, nearly 80 per cent of the children again had active decay.

I am indebted to Dr. Victor H. Siebel for this illustration here in our midst and today: Michael D. is the son of parents born in Italy, but he was born here. The Italian diet of fruit, vegetables, milk, hard bread, little meat and few sweets rules the home. At the age of 15 years Michael was 5 feet 7 inches tall, weighed 160 pounds and had perfect teeth and gums. He resented the fact that he could not have the American diet many of his boy friends enjoyed so much—unlimited quantities of meat, cooked starches and sweets. For a year now he has lived on that diet but has brushed his teeth faithfully to ward off danger. There are now eight cavities in his teeth where there was none. His gums, perfect a year ago, are now swollen and forming pus. He is headed for a dental bill and trouble.

We in our group believe that decay of the teeth is a sign of illness. We are concerned to get the person well. In doing that we find oranges, lemons, milk, vegetables generally and cod-liver oil of great value. When the person gets well, the decay usually slows down or stops.

GEORGE WOOD CLAPP, D.D.S.  
New York, Dec. 12, 1933.



## *Ask* ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado. Please enclose postage. Letters of special interest will be published.

### WHAT CAN YOU SUGGEST?

*Q.*—Ten or twelve years ago I made a common dark red upper partial denture for a woman about 65 years of age which she wore with absolute satisfaction. In the course of time she occasionally lost a tooth or met with an accident and had to have the denture repaired or a tooth added so that, finally, it seemed necessary to make her a new plate.

In order to give her the best possible service, I had the plate lined with black rubber. It fitted very comfortably and she ate with ease. However, in a few weeks her mouth became sore. There was no pain—just inflamed spots in the roof cov-

ering the rugae and extending to the anterior teeth, and also on the outside of the ridges.

I scraped and polished and ground, relieved the occlusion, and relieved over the anterior and posterior palatal canals, and the denture would feel very comfortable. Invariably, though, with a few days' wear, the inflamed condition would return. I took a new impression and made a new plate that seemed a perfect fit and right in every way. She wore it about three weeks and came in with the same old soreness.

She is not susceptible to rubber or she could not have worn the old plate ten years or more. Furthermore, the one I made a year ago was lined with black rubber.

She has no money to spend experimenting, and though I have done much to get this case right, and am willing to do more, I do not feel I can pay for gold plates nor big laboratory bills which are beyond her means. Any dentist can say, "Metal plate," but in view of her experience, what assurance is there that it would do her any good?

What further shall I do?—  
R. G. J.

A.—This is a tough one and I am afraid we cannot do much to help you out on it but we will be glad to publish your letter with an appeal to any of our readers who may have a helpful idea.

I go over the palatal surface of all new dentures with a pair of binocular magnifying lenses and it is surprising how many small nodules, bumps, and ridges I find and remove before putting the denture into the patient's mouth. I think practically all laboratories turn their cases out this way and it occurs to me that this may be a possible cause of the irritation in this mouth—V. C. SMEDLEY

### CAVITY LININGS

Q.—In the course of an oral examination of one of my patients—a man about thirty-five years of age—I noticed a buccal cavity on the lower left second molar near the occlusal third, and one cavity just beneath the marginal gingivae at the dento-cementum junction of the same tooth. Because of the

extreme sensitiveness of the tooth during the preparation, it was necessary to give a mandibular injection of novocaine.

After preparing the cavity, it seemed to me that if I were to insert a cement lining (a procedure I always follow in deep-seated cavities) there would be very little room for the amalgam filling. I, therefore, left out the lining.

For about two weeks the patient complained of pain whenever he took anything hot or cold into his mouth. During examination every time I touched the completed amalgam restoration with a steel or chromium plated instrument in the presence of saliva, the patient would experience a shock.

I have had the same experience with the upper third molar of a young woman.

Can you explain this reaction?—I. Z.

A.—Due to the greater sensitiveness of a tooth at the cervical border one is more apt to have shock from the placing of a metal filling than in any other part of the tooth. Therefore even though the filling is shallow we very frequently have the result of which you speak.

I always varnish these cavities generously if there isn't room for a cement base, but, of course, a cement base furnishes a better non-conductor than the varnish. However, the varnish helps. There is nothing you can do in these cases except remove the fillings and refill, using either varnish or a cement lining; but in all probability if



the shocking isn't too severe it will pass away within a few months.—GEORGE R. WARNER

### TEMPORARY LOSS OF SIGHT

Q.—I have had two patients recently who have complained of temporary loss of eyesight following mandibular injections. The condition subsided soon after the operation.

I am of the opinion that my technique may be faulty, due to the fact that I am using a new type of syringe. Do you think this may be the cause?

Also, can you tell me what sterilizing property 70 per cent rubbing alcohol has?—L. B. F.

A.—It is quite possible to have reflex disturbance of vision through the fifth nerve from a mandibular injection of novocaine and doesn't indicate an error in technique. In fact, the occurrence is not uncommon.

Alcohol is considered to have sterilizing properties and it is advised that from fifty or seventy per cent alcohol is more effective than the ninety-five per cent alcohol ordinarily used.—GEORGE R. WARNER

### SENSITIVE TEETH

Q.—A patient of mine has gingival erosion plus abrasion. The cavities are supersensitive, even when touched with cotton. Novocaine has no effect. The patient is pregnant, but says this condition existed prior to pregnancy.

Her teeth are in very good condition otherwise, and there is no trace of pyorrhea. Her general health is good.

Would you suggest preparing and filling the cavities under a general anesthetic, or is there any drug which, when applied, will desensitize the areas sufficiently to prepare cavities? What do you think causes the condition?

Is there any circulation in the dentine? If so, what proof can be offered?

Are the nerve fibrils in dentine the cause of shock, or is it due to an osmotic change in the fluid between the dental tubules or in the area of the isles of Tomes?

Why can you block off the main nerve in a tooth and yet receive sensation within the dentine, if the dentine contains fibrils? If this be true, it must be a change in osmotic pressure of the fluids between the dental tubules and the isles of Tomes.

What effect would some sort of pinpoint of light (such as ultra-violet or x-ray or radium) applied directly to exposed surfaces of dentine have?—L. A. C.

A.—Your problem is that of every dentist and the answer varies with individual opinion. The hypersensitiveness is probably due to the fact that the dentinal tubules and the fibrils anastomose at the dento-enamel junction so that an irritation to a few fibrils is not simply transmitted to their odontoblasts and the nerve endings in contact with, but to all the fibrils, and so to the nerves in contact with

all of the odontoblasts. (Noyes) The irritation of salt and sugar is probably an osmotic action.

There is no circulation of blood in dentine.

The cause of erosion is still a moot question. Some men think that the deep triangular shape depressions are toothbrush abrasion. Some men claim that erosion is the result of occlusal trauma. One has the idea it is due to an acid condition of the system and that the mucous from the lips is also acid and causes a dissolution of the enamel. The writer is not satisfied that the cause is yet known.

The treatment of these areas of erosion or/and abrasion should depend upon their depth and character. If not very deep and if progressing slowly with no indication of decay it would seem wise to treat them for sensitiveness and defer repair by filling as long as possible. I have a number of cases in which the sensitiveness has disappeared and the destruction has not advanced noticeably in fifteen years.

The treatment can be both local with escharotics and relief of occlusal trauma. Zinc chloride is effective, as in formalin. The latter should be applied by rubbing the dry area with a stick which has been saturated with formalin and the excess absorbed.

Why there are areas in teeth which still have sensation after a nerve block becomes effective I can't say. It happens fre-

quently, however.—GEORGE R. WARNER

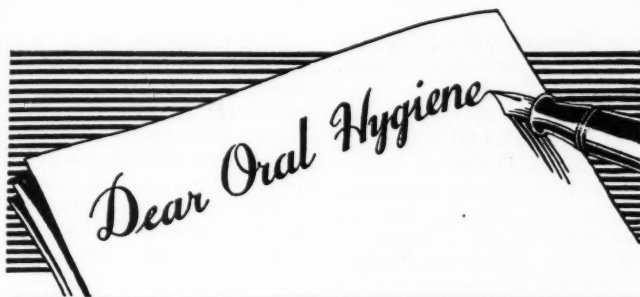
## TOOTH STAINS

Q.—I have noticed in the years that I have been practicing a type of stain I find most in young people. It is not due to smoking, nor it is the typical green stain. I find it in very clean mouths.

I recently cleaned the teeth of one patient in particular and in two weeks' time the stain reappeared. It is present lingually and buccally and is heavier near the gums.

Is there anything known that will check its recurrence?—J. G.

A.—The stains which occur on the teeth of people who do not use tobacco or drugs and who use the toothbrush efficiently are not easy to account for. In some cases it is because of a diet carrying a large amount of some particular article of food. In other cases it is probably because of defective metabolism and this latter may be associated with the former. If the diet of the patients which you mention is about the same as other members of the same family who do not have stain it may be the manner of brushing the teeth or the dentifrice used. I have some patients who have overcome the staining of their teeth by using a powder for a dentifrice instead of a paste. I suggest you have your patients try a powder if you have not already done so.—GEORGE R. WARNER



"I do not agree with anything you say, but I  
will fight to the death for your right to say it."

—Voltaire

## DATA ON IMPACTED TEETH

I should be very grateful for the assistance of anyone who has observed the effects produced by misplaced and impacted teeth in helping me to gather material for an article on this subject. Any information bearing on the points listed below would be appreciated, as would any reprints or references to articles dealing with the subject.

1. At what age and how was the tooth, or teeth, discovered?

2. At what age was the misplaced or impacted tooth removed?

3. Has malignancy been observed to follow or precede removal or failure to remove such a tooth or teeth?

4. What signs, symptoms, or effects—local, general, or special—drew attention to the impacted or misplaced tooth?

5. What method was em-

ployed to remove the tooth or teeth?

6. What anesthetic was used?

7. What result if any did the removal have upon the signs, symptoms, or effects previously mentioned?

8. Did the removal of the tooth or teeth have any other effect in addition to those just mentioned?

9. What was the sex of the patient?

10. What was the race of the patient?

11. If possible, please show the position of the tooth or teeth. Any prints of x-ray films or plates, drawings, or diagrams showing the position and relation to other teeth or structures will be very valuable. All such material sent will be returned if requested. Credit will be given for any material used, so please write name and address plainly.—ALONZO MIL-

TON NODINE, D.D.S., 117 *The Ridgway, Wimbledon, London, S. W.* 19, England

### TO EDENTULOUS PROSTHETISTS

Thirty-five years' experience in wearing dentures has led naturally to an exchange of ideas with practitioners similarly afflicted. The general opinion is that *theory* is wonderful in promoting development and progress, but *practical experience* raises many points of difference.

It is conceded that, were our theorists compelled to wear some of the wonderful productions accepted as standards of teaching, they would soon change their beliefs. Without exception this is the opinion expressed by denture-wearing dentists with whom I have come in contact.

Why is it that a dentist who formerly adhered to the highest degree of denture technique expresses such a different view when he personally experiences what he has asked his patients to endure? Why is it that invariably he finds that simplified technique and a \$2.50 articulator afford just as much comfort, service, and esthetics as the more expensive and elaborate practices?

Would it not be in order to form an association of edentulous prosthetists for the purpose of progressive development, based on actual experience, rather than theory, for the greater benefit of our permanently unfortunate patients?

Our magazines could well establish a section devoted entirely to the expressions of edentulous dentists. It would also be in order for every denture-wearing practitioner to address his opinion to the writer.

What is your reaction?—  
L. A. HAWKES, D.D.S., 128 *Oakland Avenue, Pittsburgh, Pennsylvania*

### WE DO OUR PART

While President Roosevelt last Spring was working on the slogan, "We do our part," a group of dentists from the city of Seattle were putting into effect the movement the President anticipated.

Nine dentists through the medium of the Masonic Service Bureau of Seattle voluntarily came to Skykomish, a small town in western Washington, for the purpose of donating their services to the children of the unemployed in that section.

The children's teeth had been neglected for three years. Their fathers, loggers and mill workers, had been unemployed for that length of time owing to the local lumber mill's shut-down.

The dentists established a clinic at the school. The superintendent of schools acted as business manager and a corps of high school boys and girls assisted as nurses and helpers. Swivel chairs from the offices of the depot agent, the mill superintendent, and the school superintendent, a barber's chair

and old-fashioned rockers formed part of the equipment.

The dentists worked four days, the first day given over to examinations. One day was set aside for the children of the outlying districts. Pre-school children and adults, as well as school children, were treated, one woman having twenty-five extractions.

One dentist gave his time exclusively to extractions, the other eight attended to the fillings.

Early patients came at seven a.m. Late patients remained until seven p.m.

When the work was done and checked over, it was found that these men, these professionals in every way (too modest to allow their names in print), had done a monumental thing for a small town in its hour of need. Their services represented a gift of a \$1500 piece of work, embracing 514 fillings and 204 extractions.

In June, at the close of school, they returned to complete unfinished work.

With the Fall opening of school they mailed 200 tooth-brushes and tubes of tooth paste to the children, as a fitting conclusion for the "something we have done for humanity," quoting the words of one of the dentists.—MRS. ISABEL LAWRENCE, *Skykomish, Washington*

## ADVICE VERSUS TRAINING

To the list of economic cures

of the "New Era" of 1924-1929 and of the "Forgotten Man Era" of 1933—? I must add Dr. Edwin Blass's dental panacea\*—which is one more theory at the expense of the gullible public.

Doctor Blass suggests that, if for no other reason save monetary considerations, orthodontia is one method of correcting a financially distressed dental practice. One of the doctor's theories, which is quite old in fact, is to have the dentist send impressions of a child's upper and lower arches to a "qualified" laboratory for advice and construction of appliances. In his own words, some of these "institutions" have specially trained orthodontists to supervise and give advice to general practitioners.

Giving advice even in simple cases of orthodontia, as in many other matters, is very easy. To carry a so-called simple orthodontia case through in mixed dentures in children's mouths is another matter. Orthodontists of real ability recognize this. To me, and I am sure to hundreds of other dentists and orthodontists, the idea that a dentist attempt to practice orthodontia under circumstances outlined by Doctor Blass, without having had a comprehensive postgraduate course of instruction, or a thorough collegiate training (which incidentally has been ignored

\*ORAL HYGIENE, October, 1933, p. 1480.

by the colleges), means a degrading of orthodontia, a step backward in professional practice, an encouragement of irresponsible laboratories "advising" dentists, and a threat to the child welfare of the nation.

I wonder what Angle, Dewey, Hellman, Casto, and men of their ability and ideals would think of Doctor Blass's theory of orthodontia practice and its effect on the dentists' welfare and their patients' health and appearance? I wonder whether Doctor Blass has his tongue in his cheek, or is he in earnest? —MEYER COHEN, D.D.S., *Brooklyn, New York*

### DENTISTRY AND POLITICS

My first thought was, "If I ever tear loose and write something really foolish, and then do not tear it up but send it to an editor, I hope the editor will consider me and suppress my sophomoric effusion instead of printing it, as he did Doctor Machat's\*, with such a wise and superior editorial†, to show the world what a fool I was."

But, from an astronomical point of view, considering, not my feelings, but "that far-off divine event which the whole creation moves," perhaps such an effusion ought to be used to point a moral. We peer so closely at teeth that we forget

there are other things more important.

A certain proportion of idealistic socialists, like Doctor Machat, is desirable in a democracy. Very few dentists are mentally equipped to discuss political or economic or social questions; but we all have the vote—for which we are equally ill-equipped.

The moral is that dentists should stick to teeth and not write to editors except on dental subjects as far as possible removed from politics and other things which they know nothing about. Or, if they obey that impulse, let them accept the bumps. Then editors would have less to print, and printers could join the CCC and plant pulp wood. Dentists then would have less to read, and more time to fix teeth.

But, on the other hand, we're supposed to vote, and how can we come anywhere near voting right unless we think a good deal about politics? Since the best aids to thought are writing and discussion, we should all write and discuss politics, in spite of how little we know about them.

Anybody who can't fix teeth well ought not to practice dentistry, but in a democracy we all must practice politics, so all should devote a reasonable part of our abilities to becoming competent politicians, however much we'd rather tend to something else.—JOSEPH L. BARBER, D.D.S., *Coronado, California*

\*ORAL HYGIENE, September, 1933, p. 1352. †*Ibid.*, p. 1364.

# Tempus FUGIT



Twenty years  
ago

## THE BUSINESS SIDE OF DENTISTRY

The editorial note introducing an article by Dr. F. Irwin Shaffer, Johnstown, Pennsylvania, is sufficient indication that twenty years ago the business side of dentistry was a new subject for discussion; and the quantity of material on the same topic printed today is proof that it has not yet been exhausted.

*"I am printing this paper because I want to see whether it voices the sentiments of any considerable portion of the profession, and I would be glad to get your opinion on the subject matter as presented in form for printing.—Editor.*

"The question of fees is a tantalizing one. We are not like contractors or builders; we cannot make our estimates, and then add 20 or 30 per cent, and charge accordingly. This is impossible from the very nature of our work. Someone may absolutely need assistance to build up and retain his health, and the burden sometimes falls upon us to render that assistance, knowing that we shall receive no pecuniary reward. But not all our patients are

poor. A man or woman worth a million should properly pay for service that will enable him to enjoy his wealth and the ease afforded by that wealth.

"A successful business man, by reason of our service, is often enabled to give closer and better attention to business. In such a case the dentist should get his share of the probable increase in the business man's income.

"Of course, whatever work we do, whether for the poor man or the rich man, should be done to the best of our ability. But at all times the dentist should consider all his fixed charges; expense of office, family, interest on investment, and everything necessary for him to live properly and make advancement professionally. Then at all times, and from all patients, he should charge sufficiently to meet all these demands. Patients who can afford it should meet the demands of the dentist in laying aside something for a rainy day or old age. In other words, such patients should pay a little bonus that we may invest to the best advantage."



# LAFFODONTIA



*If you have a story that appeals to you as funny, send it in to the editor. He MAY print it—but he won't send it back.*

Bride: "You didn't talk that way before we were married!"

Groom: "What way?"

Bride: "You said you would go through fire and water for me, and now you refuse when I ask you for money."

Groom: "But I never said I'd go through bankruptcy for you."

A member of Congress was very much impressed with the dignity of his position, and it was always on his mind. One night his wife awakened him and whispered:

"John, there are burglars in the house."

"You must be mistaken, my dear," he answered. "There may be a few in the Senate, but in the House—oh, no; the idea is preposterous."

Sandy Macpherson and Maggie, his wife, stopped in front of a restaurant window in which was hung a card bearing the words, "Luncheon from 12 to 2 p.m., 1s. 6d."

"We'll have our lunch here, Maggie," said Sandy. "Two hours' steady eating for 1s. 6d. is no' sae bad."

First Customer: "Waiter, bring me a plate of hash."

Waiter (calling back to the kitchen): "Gentleman says he'll risk it."

Second Customer: "Waiter, I'll take the same."

Waiter (calling back to the same kitchen): "Another sport!"

Teacher: "What is the formula for water?"

Willie: "H I J K L M N O."

Teacher: "Nonsense!"

Willie: "You said yesterday it was H to O."

The class listened with bated breath to the teacher's account of her encounter with a road bandit.

With dramatic gestures she reached the climax of her story, and concluded by saying:

"And then I fainted."

Little Freddie gazed with awe and admiration at his teacher. Suddenly he asked:

"With your left or your right, teacher?"

Lady customer in shoe store: "Of course, I want them comfortable, but at the same time good looking and attractive."

Clerk: "Yes, madam, I understand—large inside and small outside."

An Englishman, endeavoring to get a connection with a friend over the long distance telephone, was having difficulty in making the operator understand the name of the exchange, which was Ealing.

Finally, in desperation, he said: "E—for 'erbert, A—wot 'orses eat, L—where yer goes to when yer dies, I—for ingine, them things in front of trines, N—wot lays eggs, C—for gor-blime. Now, 'ave yer got it?"